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Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
21 floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange	Commissioner
P.S.A. Lamak, Q.C.	Counsel
E.A. Cronk	Associate Counsel
Thomas Millar	Administrator

Transcript of evidence
for

June 21, 1984

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS

Hearing held on the 21st Floor,
180 Dundas Street West, Toronto,
Ontario, on Thursday, the 21st
day of June, 1984.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Administrator

APPEARANCES:

E. CRONK)	Commission Counsel
D. HUNT)	Counsel for the Attorney
L. CECCHETTO)	General and Solicitor General
		of Ontario (Crown Attorneys
		and Coroner's Office)
M. THOMSON)	Counsel for The Hospital for
R. BATTY)	Sick Children
D. YOUNG		Counsel for The Metropolitan
		Toronto Police
W.N. ORTVED		Counsel for numerous Doctors
		at The Hospital for Sick
		Children
D. BROWN		Counsel for Susan Nelles -
		Nurse
P. RAE		Counsel for Phyllis Trayner -
		Nurse
J.A. OLAH		Counsel for Janet Brownless -
		R.N.A.

... (Cont'd)



APPEARANCES: (Continued)

S. LABOW

Counsel for Mr. & Mrs.
Gosselin, Mr. & Mrs. Gionas,
Mr. & Mrs. Inwood, Mr. & Mrs.
Turner, Mr. & Mrs. Lutes,
and Mr. & Mrs. Murphy (parents
of deceased children)

F.J. SHANAHAN

Counsel for Mr. & Mrs. Dominic
Lombardo (parents of deceased
child Stephanie Lombardo); and
Heather Dawson (mother of
deceased child Amber Dawson)


W.W. TOBIAS

Counsel for Mr. & Mrs. Hines
(parents of deceased child
Jordan Hines)

J. SHINEHOFT

Counsel for Lorie Pacsai and
Kevin Garnet (parents of
deceased child Kevin Pacsai)

VOLUME 159



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1

RD/ko

2

--- On commencing at 10:00 a.m.

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THE COMMISSIONER: Yes, Mr. Shinehoft.

4

MR. YOUNG: Excuse me, Mr. Commissioner.

5

Before we begin I have made some enquiries with

6

Mr. Percival and our clients and we, too, would prefer

7

the week of the 23rd.

8

THE COMMISSIONER: Is there anybody
wildly opposed to the 23rd? Miss Cecchetto, you are?

9

10

MS. CECCHETTO: I have no opposition
to the week of the 23rd. What we were going to ask for,
and we recognize it may be a real problem, sir, is that
Mr. Hunt and I were hoping for the week of the 16th,
actually, because there is a criminal law course that
Mr. Hunt will be teaching and he is scheduled to
presently teach at.

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THE COMMISSIONER: What date does he
teach at, the whole week?

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MS. CECCHETTO: It is scheduled for
the whole week and for the whole weekend, too. We
present it to you. We recognize there may be a
problem.

21

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THE COMMISSIONER: The real problem
is that we just have two weeks in July now. You are
not teaching at this?

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MS. CECCHETTO: No, I am not.



1
2 THE COMMISSIONER: I don't know. We
3 can certainly adjust so that your clients are not on
4 at the time, someone else's clients would be on. I
5 think we can do that, can't we, Miss Cronk?

6 MS. CRONK: Yes, certainly, sir.

7 THE COMMISSIONER: Where is the course
8 being held?

9 MS. CECCHETTO: New Brunswick.

10 MS. CRONK: I see no reason that he
11 cannot commute, sir. It is perfectly obvious that
12 some of us have gone to great lengths to accommodate.

13 THE COMMISSIONER: We will certainly
14 have someone, certainly ensure that someone is
15 scheduled who is not your client and if necessary we
16 can postpone cross-examination and that sort of thing.
17 It will be worked out somehow or another, but we will
18 do the best we can.

19 I think if we took that out we might as
20 well write July off entirely.

21 MS. CECCHETTO: I would have no serious
22 opposition, but I am not suggesting it.

23 THE COMMISSIONER: I think we will
24 settle on the 23rd and the 30th of July, the two weeks
25 that we will take off, and we will come back -- is
that the August holiday, Monday? At any rate, it



1
2 doesn't make any difference. We will come back on
3 the 7th in any event. It is a Tuesday.

4 Yes, all right.

5 MR. YOUNG: Miss Thomson would like
6 to know what plans we are making for the Christmas
7 break?

8 THE COMMISSIONER: There are two good
9 chances, one is that we will be finished and the other
10 is if we are not I will be.

11 ARGUMENT BY MR. SHINEHOFT: (Continued)

12 Well, I am almost finished,
13 Mr. Commissioner, but I would like to make one or two
14 further comments with regard to the theory, as suggested
15 by Dr. Bain. That is I would ask you, as well, to take
16 into consideration the evidence of the cardiologists,
17 who it is my understanding, not one of the cardiologists
18 have ever heard of the condition of transient adrenal
19 insufficiency, as well as Dr. Cutz and the other
20 pathologists, none of whom have ever heard of that
21 condition.

22 Dr. Kauffman, who is both a pediatrician
23 and a clinical pharmacologist, who gave evidence here,
24 said that it may have happened, but he never gave a
25 diagnosis of this condition and, as well, the lack of
a reasonable explanation for the high digoxin level.



1
2 Dr. Bain has given his theory and I
3 will discuss it, that a high potassium level may in fact
4 elevate the digoxin level, but I would point out to
5 you that this is unsubstantiated in any of the
6 literature that has ever been published and
7 Dr. Kauffman has given evidence here that the reverse
8 is often true and, as you will recall, Mr. Commissioner,
9 when Dr. Kauffman last came here and certain articles were
10 filed as exhibits through Dr. Kauffman and I think they
11 again substantiate the view that a high digoxin level
12 can elevate the potassium level, but again the reverse
is not true.

13 Finally, Dr. Bain, in all fairness and
14 candor, did admit that this child could very well have
15 died from an overdose of digoxin. He does not exclude
that possibility.

16 So just to summarize, it is my view,
17 Mr. Commissioner, my submission that this theory is
18 exactly, as Mr. Lamek has said, a theory. There is
19 ample evidence to allow you, Mr. Commissioner, to come
20 to a different conclusion and I would suggest that the
21 digoxin evidence is overwhelming and that this theory,
as advanced by Dr. Bain, should be discarded.

22 The next theory that was advanced, as
23 far as the possible cause of death, was that of
24
25



1
2 Dr. Spielberg and the question of pathophysiological
3 changes that might have occurred in the child.

4 Dr. Spielberg, I believe, hangs his hat
5 on two things: Firstly, the fact that the child
6 reverted back to normal sinus rhythm while in the
7 Intensive Care Unit and, secondly, the Gary Murphy
8 case. He analogized Kevin Pacsai to Gary Murphy.

9 Now, I would point out the evidence of
10 Drs. Hastreiter and Kauffman in this regard. Dealing
11 firstly with Dr. Hastreiter, and when asked about the
12 question of reversion back to normal sinus rhythm, says
13 at page 7451, and I am sorry, Mr. Commissioner, I don't
14 have the volume number. He says to the following
15 question:

16 "Q. So that this is not an infrequent
17 phenomena, and has that been reported
18 in the literature, to your knowledge,
19 Doctor?

20 A. Oh, yes, yes."

21 Dr. Kauffman, who was asked the question as well at
22 page 6519 says:

23 "I can answer it to the extent that
24 it is consistent with some of the
25 reports in the literature of what
happens with the heart during digoxin



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"toxicity and non-intoxication and I
suspect that what is going on is
that the digoxin has the electrical
characteristics of the heart
deranged that you have multiple
sites in the heart initiating..."

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et cetera. So what he is saying again, this is not
an infrequent phenomena and has again been reported
in the literature, this reversion back to normal
sinus rhythm.

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The second part of Dr. Spielberg's
theory is based on the Gary Murphy case and
Dr. Hastreiter is asked to compare the two and he says
at page 7454, when asked to make this comparison,
says:

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"A. I don't see ...and comparison...
at all other than their post mortem
digoxin concentrations."

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He goes on to say that there are important differences
between the two, namely Baby Pacsai had a structurally
normal heart and good circulation and Baby Murphy had
a severe, one of the most severe types of heart
problems that one can imagine and he had poor
circulation.

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2 Secondly, Baby Pacsai had pre mortem
3 blood levels and Murphy did not.

4 Dr. Hastreiter went on to say:

5 "I could never use the same explana-
6 tion for Pacsai, because Pacsai
7 simply had a circulation and that
8 could never be the situation."

9 So they are comparable in the sense that their post
10 mortem blood levels were of similar magnitude. That
11 is what Dr. Hastreiter says about this.

12 Dr. Kauffman, who was the clinical
13 pharmacologist, who gave evidence at the Gary Murphy
14 inquest, said at page 6512:

15 "A. I cannot put those two patients
16 in the same category at all.

17 The only similarities that I really
18 see is that their post mortem serum
19 concentrations were almost identical ..."

20 He goes on to say that Gary Murphy was six or seven
21 months old and Pacsai was a few weeks old.

22 "Gary Murphy had severe cyanotic
23 heart disease with a very complex
24 anatomical abnormality. Kevin Pacsai
25 had no anatomical abnormality ...
he didn't have (the) dysrhythmia



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"he seemed to be oxygenating and
having normal cardiac output as
near as I could tell from reading
his record."

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2 I don't see them comparable at all
3 other than the post mortem digoxin concentrations.

4 So, again, you have the very doctor
5 who gave evidence at the Murphy inquest as saying
6 you are comparing, really, apples and oranges.

7 Now, the third pharmacologist that has
8 given evidence is Dr. MacLeod, according to Mr.
9 Scott, said that he now accepts the pathophysiology
10 theory as to what happened to Kevin Pacsai.

11 Well, now in that regard, Mr.
12 Commissioner, I would like to refer you to Page 9,
13 Tab 32 of the material prepared by the Hospital.

14 THE COMMISSIONER: Tab...?

15 MR. SHINEHOFT: Tab 32, Mr. Commissioner.
16 And it is the ninth page. At the bottom it starts
17 "Dr. MacLeod - cause of death."

18 THE COMMISSIONER: All right.

19 MR. SHINEHOFT: If I could just review
20 that with you.

21 Dr. MacLeod suggests that Pacsai
22 probably received an excess dosage of digoxin
23 while at the same time acknowledging pathophysiology
24 as a distinct possibility because of the high potassium
25 in the acid doses. He rates the probability as a
75% for digoxin overdose versus 25% for pathophysiology



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2
3 with the provisal that Murphy inquest strengthens the
4 argument for pathophysiology as the cause of death.

5 Then, the following pages it says,
6 under cross-examination by myself, Dr. MacLeod offered
7 three causes of death: Digoxin overdose; metabolic
8 disorder; cardiac conduction disturbance.

9 With regards to the estimate of 75/25,
10 MacLeod acknowledges that is purely intuitive estimate
11 on his part while also acknowledging that the
12 pathophysiology remains a nebulous concept.

13 And then further, under cross-examination
14 of Olah, MacLeod further discusses the pathophysiology
15 but concludes that digoxin overdose is the probable
16 cause of death.

17 So, I would say that from a reasonable
18 reading of that that the only supporter, really, that
19 the doctor had was -- Dr. Spielberg has -- is himself
20 that this theory has not been accepted by any of the
21 other clinical pharmacologists and, again, is a
22 theory only.

23 There is, in my submission, ample data for
24 you, Mr. Commissioner, to disregard that theory and
25 that you should, in fact, disregard that theory as
a possible cause of death of this child.



1
2 Now, further, I would like to point
3 out that Dr. Kauffman, who prepared the pharmacological
4 data for the Atlanta Report, says that it rates
5 Pacsai on a scale of 0 to 5 is 4 and that Cook was
6 the only one that was rated as a 5. And in order
7 to get a rating of 5 one of the criteria was that
8 you would have never had to receive digoxin before, so
9 that it was literally impossible for Pacsai to receive
10 a rating of 5 because it is acknowledged he had
11 received digoxin while in Hamilton.

12 So, I would suggest that the rating
13 of 4 would be the highest rating that could possibly
14 have been given this child by Dr. Kauffman.

15 Now, it is my submission that this
16 child died as a result of an overdose of digoxin,
17 and that it is unlikely to have been given accidentally.
18 I am of the opinion that the child died suddenly and
19 unexpectedly and as a result of a deliberate over-
20 dose of digoxin.

21 The best illustration I can give you
22 of this is the evidence of Dr. Malcolmson, the
23 treating physician at Hamilton.

24 Now, Dr. Malcolmson states that at
25 Volume 2 of the preliminary hearing, Page 359, at line
26 22, he says:



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"I called Dr. Olley..."

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And that is the doctor to whom the baby
was referred initially...

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"... at the Hospital for Sick Children
to find out what had happened to Kevin
and he told me that he had died which
surprised me. I am not usually sur-
prised very often in situations like
this but that certainly did and I
couldn't understand why.

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As well, I would ask you to take into
consideration the evidence of the doctors and of the
nurses that they have given evidence. The ones that
have dealt directly with this child that he was well
on his admission to the Hospital for Sick Children.
He died less than 19 hours later. His death was
sudden and unexpected and unexplained by his anatomical
condition.

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So, it is my submission, Mr. Commissioner,
that the evidence is overwhelming that this baby died
as a result of a digoxin overdose and that of such
a magnitude that it is unlikely that such a dose was
given accidentally.

23

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The only digoxin that the child
received -- the only prescribed digoxin that the child



1
2 received at Toronto was 0.02 milligrams given by
3 Susan Nelles and she has steadfastly maintained that
4 the dosage was properly drawn. It was drawn in a
5 1 cc tuberculin syringe and that it was checked, I
6 believe, by Mary Jean Halpenny, and that it was
7 properly administered.

8 There has been no evidence of any
9 unprescribed medication error given to this child.
10 So, I voice no comment in regard to the circumstances
11 under which this overdose was given and because I
12 believe that I am precluded from doing so although
13 the reality of the situation --

14 THE COMMISSIONER: You are not pre-
15 cluded but --

16 MR. SHINEHOFT: I would prefer not to.

17 THE COMMISSIONER: Yes.

18 MR. SHINEHOFT: Although I will say
19 this, Mr. Commissioner. The reality of the situation
20 is such that it must have been done by somebody. This
21 cannot occur in a vacuum and it is a matter that I
22 think should be examined by proper authorities for
23 further dealings, if they deem that they are warranted.

24 I mean, if someone -- it is unrealistic
25 to suggest that someone died as a deliberate overdose
of a drug and to say that no one administered this



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drug because realistically someone did.

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I just would like to make a comment about the medication error theory advanced by Mr. Strathy and just point out that Mr. Bain, in his evidence, and he's been a pediatrician of many, many years, indicated, it is my understanding, that in all his years of experience he never saw a child die as a result of a medication error.

Lastly, I would like to comment -- I make one or two comments on the proceedings themselves, Mr. Commissioner.

I would like to thank the other Counsel for their cooperation in providing me whatever information and assistance that I required and needed and, as well as yourself, who for the most part, anyway, has been patient and understanding.

As the Divisional Court has said, never is there a case where the interests of the parties are so diametrically opposite and to go through these proceedings for the length of time that we have, without further acrimony or further arguments I think, is a very good sign. I would like to thank you for your understanding and patience with myself, Mr. Commissioner.

THE COMMISSIONER: Thank you, Mr.



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Shinehoft.

3

MR. SHINEHOFT: Thank you.

4

THE COMMISSIONER: Yes, Mr. Tobias?

5

What about Mr. Olah? He is not here?

6

MR. TOBIAS: I spoke with Mr. Olah
last evening and he is content that I precede him.

7

THE COMMISSIONER: Yes.

8

MR. TOBIAS: He intended to be here
before the lunch break, I believe.

10

THE COMMISSIONER: He better be content
to procede because he is the one that asked for the
favour in the first place.

11

12

MR. SHINEHOFT: Thank you, Mr. Commissioner.

13

ARGUMENT BY MR. TOBIAS:

14

Sir, all Counsel, or many Counsel,
have begun their submissions with a few words of
thanks. I would like to do likewise. In particular,
I would like to thank someone who has been rather
inconspicuous but without whose help I would have been
in trouble in on a great many occasions, and that is
my student, Miss Sharon Hurstberg. I would like to
thank her for her assistance in connection with all of
the endeavours I have been engaged in before you.

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And in particular with respect to her very substantial contribution that she made in connection with the written submissions that were put before you. If there is any credit at all for our argument, sir, I want to indicate that she deserves equal measure of the credit.

Now if there is any criticism, that I will take exclusively. She deserves no criticism for it.

It was said in his judgment in the Divisional Court by Mr. Justice Krever who, as you know, sir, is no stranger to Royal Commissions, that it was "... hard to imagine any case in which the competing interests of the various parties clash more resoundingly than in this one."

In my submission this may very well prove to be the most accurate and succinct observation with respect to this Commission to date, and it is a credit in my submission to you, sir, that your voyage through such troubled waters which has occupied you now for some one year has been discharged by you in such an even handed manner and that it was such a smooth voyage.

Under very difficult circumstances and under immense pressure and as well under the ever



1
2 watchful eye of the electronic and print media you
3 conducted an extremely taxing proceeding and an
4 extremely difficult inquiry and have discharged your
5 responsibilities in my submission in an exemplary
6 manner.

7 In short, sir, you have combined equal
8 parts of patience, judiciousness, with a healthy measure
9 of good humour and stoicism, and you have added, sir,
10 a small but a perfectly understandable dash of
11 irritability in order to add some flavour to the
12 recipe. The fact is, sir, that you bake one hell of
a cake and I think you can be very proud of it.

13 In the result you have earned certainly
14 my respect and the respect and admiration of the
15 parents of Jordan Hines, the public generally, and I
daresay of all parties to this Inquiry and your Counsel.

16 Myself and my clients are indeed
17 grateful to you and wish to publicly thank you for
18 and acknowledge the model fashion in which you have
19 conducted these proceedings. I spoke to my clients
20 this morning before they left for an overseas trip,
21 and they told me that they are looking forward with
22 great anticipation to the publication of your report
23 and in particular with the assurance that it will be
24 fair, it will be judicious and in a very real sense
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C 3 the most definitive judgment that can be brought to bear on the question of their son's death, given the inherent difficulties that have confronted you in this matter.

I would also like to offer very sincere thanks in particular to Mr. Lamek and Miss Cronk. It has been a pleasure to work with them. They have been of invaluable assistance to myself and I daresay to most other Counsel. No request that I ever made for information or for help was ever denied, and I think they have gone out of their way to be fair in their presentation of the evidence and to be of great assistance to all the Counsel, and I think that generally that can be said of all the Commission staff and of all Counsel who have appeared before you here.

We have had our differences from time to time, there is no question about that, and we will have our differences in future again, but my perception is that Counsel have conducted themselves in a fair and honourable manner and have gone out of their way to make available all relevant information. Not only for Commission staff but where appropriate for other Counsel.

I would like to spend just a very brief few moments in explaining the approach that I



1
2 wish to take to argument, and in particular to written
3 argument. My oral submissions obviously are meant to
4 highlight and stress what appear in our written
5 submissions. They are not meant to supplement it.
6 In fact the written argument stands on its own by
7 itself, and quite independent from anything that I say
8 to you in oral argument.

9 Parts of the written argument will not
10 be referred to orally, but this does not mean that
11 those submissions do not form part of the argument.
12 They are in the written argument and when you have the
13 time you will deal with them and I am sure give them
14 the weight that they deserve.

15 In effect we are really prepared to
16 rest our case I suppose on the written submissions
17 which have been presented to you, and we only intend
18 to highlight those portions which we think bring
19 together all the threads in the Jordan Hines case in
20 making oral submissions to you.

21 Now it is somewhat presumptuous to
22 comment to you on the approach that we recommend here
23 in analyzing the Hines case, but notwithstanding that
24 it may be somewhat helpful. At least in the sense that
25 you will understand better the written argument and how
it was put together.



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I suggest to you, sir, it is a good approach, and we feel it will be helpful to you in your analysis of the Hines death. We also wish as Mr. Scott did to make some submissions to you this morning regarding the appropriate standards which you should adopt.

First of all, and if you follow along, sir, in the written text --

THE COMMISSIONER: Yes.

MR. TOBIAS: Only with the headings --

THE COMMISSIONER: Yes.

MR. TOBIAS: -- I think it all falls together.

THE COMMISSIONER: Should we make this an exhibit?

MR. TOBIAS: I am not sure that that is really necessary.

THE COMMISSIONER: Well, we have done it with the others, that's all.

MR. TOBIAS: I don't know what exhibit number that would be, sir.

THE REGISTRAR: 431.

THE COMMISSIONER: 431.

--- EXHIBIT NO. 431: Written submissions of Mr. Tobias.



1
2 MR. TOBIAS: Thank you, sir.

3 I should say from the outset that we
4 didn't intend to leave any Counsel out, but given the
5 time and the costs involved in photocopying, we have
6 only been able to make a few copies available and they
7 were distributed to Commission Counsel, to the
8 Attorney General's Office and to Miss Thomson. If
9 any other Counsel that they really need written
10 submissions we will of course arrange to have copies
made for them.

11 The approach that we are urging upon
12 you in terms of how you should analyze the case is
13 as follows and it consists basically, sir, of some
14 10 steps. We believe that obviously the starting
15 point has to be a review of the basic data which is
set out on page 1 of the written argument.

16 We would then suggest that it would
17 be helpful to examine the history of the child as
18 related to us here at this Commission by his mother.
19 You will recall Dr. Bain saying the history and
20 physical examination are 95% of the diagnosis, and
21 that a very large component of that history is the
22 observations of the mother because she can tell when
a baby is not well; she can tell when a baby is sick.

23 Mrs. Hines' evidence was called for
24
25



1
2 that very purpose because so much turns in this case
3 on the analysis of what was seen clinically, and
4 basically pages 2 to 4 of our written argument canvass
5 her evidence in terms of the history.

6 We suggest the next logical step is
7 then to review the diagnosis at North York General
8 Hospital, their presumptive diagnosis on discharge,
9 and as well the diagnosis at the Hospital for Sick
10 Children, the treatment rendered at the Hospital for
11 Sick Children and the clinical course of the child.

12 The clinical course divorced entirely
13 from the digoxin data, and that clinical course
14 obviously also includes the terminal events. And all
15 of that evidence, a summary of it, is set out on pages
16 4 to 8 of our written argument.

17 Now having gone that far into the
18 analysis, what we are suggesting is that the next
19 logical step --

20 THE COMMISSIONER: Sorry, just so that
21 I will have these numbers correctly, is this Step 1?

22 MR. TOBIAS: No, Step 1 was the review
23 of the basic data. Step 2 the history of the child as
24 related by the mother.

25 THE COMMISSIONER: Yes.

MR. TOBIAS: Step 3, diagnosis at



1
C 8 2 North York and at Sick Kids.

3 THE COMMISSIONER: Yes.

4 MR. TOBIAS: The treatment and the
5 clinical course.

6 THE COMMISSIONER: That is all part
7 of 3?

8 MR. TOBIAS: All part of 3, and that
9 is divorced from the digoxin data.

10 Now having gone that far in the process
11 we suggest that the logical Step No. 4 is to take note
12 of the various possibilities regarding the cause of
13 death posed by the various medical and pathological
14 experts both inside and outside of the hospital. Not
15 necessarily at this point in your reasoning process
16 to look at their judgment on each other's diagnosis,
17 but your first exercise we suggest is that at this
18 point you should only canvass and be looking at and
19 making a mental note of all the various possibilities
20 that have been thrown out: sort of taking stock of
21 what their opinions were.

22 Step 5 is to then examine the opinion
23 of the various medical and pathological experts as to
24 which cause of death out of the various possibilities
25 that have been put forward they presently accept. And
then we suggest that the next step, which is Step 6,



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is that at that point and only at that point having
thoroughly canvassed the facts and the opinions which
form the basis for your deliberations should you then
commence to examine in depth the various possibilities
with respect to cause of death which the experts have
urged upon you which have not been ruled out.

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So you start by looking at all of the theories thrown out, what their present view of it is and you are going to be left, after a process of distillation with two or three possibilities left and only at that point can you then logically start to look in depth at what merit there is in those various points of view.

The first of those possibilities, and this is Step 7, sir, is sudden infant death syndrome. We suggest to you that there are basically four areas, four questions which you should address in connection with that potential diagnosis and cause of death. They are as follows: first of all, to avoid some of the confusion that was apparently created last October in Dr. Becker's evidence, I think it is important to distil it and understand thoroughly the distinction he contends for between missed SIDS and SIDS.

The next area to question is the significance, if any, of the presence of the four pathological markers which were seen at autopsy in combination with the periods of apnea.

The next question, with respect to SIDS is the relationship between sudden infant death syndrome and arrhythmias and Dr. Becker's hypothesis in that connection.



1
2 Then , finally, in connection with
3 sudden infant death syndrome we must canvass certain
4 general questions related to sudden infant death
5 syndrome with respect to, first of all, it being
6 a diagnosis of exclusion and, second of all, the
7 reservations of some of the experts that they have
8 with respect to the particular case; whether or not
9 the fact that this child was in the hospital being
10 monitored is of any significance, and does that tell us
11 anything. Also, what if any significance can we attach to
12 the observations which were apparently made at home
13 by the mother.

14 At that point you are into Step 8, and
15 what we suggest is a logical approach to the case and
16 that is to look at the second possible explanation which
17 has been put forward by the experts and that is
18 digoxin intoxication.

19 With respect to digoxin intoxication
20 there are basically two questions which you must
21 canvass: first of all what is the meaning of the
22 digoxin data with respect to the Hines case? Then
23 after that, and it is important, sir, in my submission,
24 sir, that you canvass that question first because
25 only once you have understood the what expert's views are
of what the meaning is can you then go on to the



1
2 second question in connection with digoxin and that
3 is the conclusions which the various experts have
4 reached in relation to that diagnosis and the role
5 in their opinion that it played in the child's
6 death.

7 Now, Step 9 is of particular importance,
8 sir, and it will become apparent to you towards the
9 end of my argument as to why it is so critical.
10 Having examined in considerable detail the two main
11 causes postulated by the various experts and only
12 then, only after you have had a thorough review of
13 those two, you should, in our submission, look at
14 other possible causes which have still not, as yet,
15 been conclusively ruled out. You must look at them
16 to see, number 1, if they may explain the death or
17 equally, as importantly, if they may cast any light
18 at all upon which of the main causes put forward is on
19 a balance of probabilities most likely.

20 Now, let me just stop for one moment if
21 I may to elaborate on that point. It may be entirely
22 possible, although I submit on the facts here that
23 a case isn't made out for this, but it may be fairly
24 possible to explain the presence of digoxin on the
25 basis of some other illness, or the contrary view
the opposite view the one that I will be urging on



1
2 you, it may be entirely possible to explain what
3 Dr. Becker saw on autopsy in light of one of these
4 other postulated diagnosis.

5 Looking at those other illnesses,
6 the first and the most important, in my submission,
7 is sick sinus syndrome. There is a discussion of that
8 at page 41 to 43 of our written argument.

9 In particular, you should examine,
10 as part of that diagnosis, the relationship, if any,
11 between periods of apnea and bradycardia. You may
12 also look at sepsis as a possible cause on the basis
13 of Dr. Kauffman's refusal to rule it out in spite of
14 the verology findings in the autopsy report, but I
15 suggest to you, sir, that I don't think that that
16 particular analysis would be of any great assistance
17 to you. I think it is a non-starter.

18 Finally, the Tenth Step. Having thus
19 analysed the evidence with respect to the cause of
20 death of this child and weighed the various possibilities
21 should you conclude the child died, as a result of
22 digoxin intoxication, you should then turn your mind
23 to the question of medication error and in your
24 consideration of that matter we suggest that you
25 address yourself to the following issues: firstly,
what types of medical errors are possible in this



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2 case? You don't have to be a doctor to analyse that.

3 1. Having laid out what the possibilities
4 are then you have to look at how likely it is
5 with respect to each particular error that it could
6 have happened and in canvassing that possibility
7 you should be looking at five things: first the
8 digoxin data; second, the evidence with respect to
9 the availability of digoxin on the ward at the time
10 of Jordan Hines death, and the times of its normal
11 administration and the manner of its normal
12 administration. Thirdly, you should be looking at
13 the nature of the child's terminal events; fourthly, the
14 nature of and the mode of the administration of
15 the drugs that he was prescribed and he was supposed
16 to be getting, and the physical form in which they
17 were available on the ward; and lastly, the evidence
18 of the experts regarding the likelihood of that
19 scenario.

20 If you take that approach, if it
21 recommends itself to you, I think that in the end
22 the case falls into place and can be dealt with in a
23 very logical and precise manner.

24 Now, a word, if I may, sir, regarding
25 standards, because we, as well, have some views on
what standards you should follow.



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I think first and foremost, and of critical significance is that you must surely look at this whole series of deaths and you must analyse and weigh the facts of each case, each and every case, all 36, against the backdrop of that series. You can never lose sight of the fact that what happened in the hospital in the epidemic period was not a series of isolated and unique events. To suggest otherwise is to suggest that like the proverbial ostrich, you bury your head in the sand. You simply can't ignore the series. It is an impossibility. It is almost as ridiculous as saying, in connection with the holocaust, that you must look at six million individual cases and ignore the historical realities. It is inconceivable, in my submission, that you could be urged to ignore the series.

The second standard is that the balance of probabilities unquestionably here is the appropriate test, and, in my submission, it need not be put any higher than that due to the impact your decision might have.

The standard in a civil case is a balance of probabilities and I don't think any one would argue that in some civil cases the impact of the decision is devastating on the parties. You don't



1
2 make your standard higher, you don't increase the
3 burden of proof, because you are looking at a serious
4 question.

5 THE COMMISSIONER: The law seems to
6 be -- I may be mistating it -- but it seems to be
7 that where the effect on the parties is greater
8 you are required, within the balance of probabilities
9 rule a greater standard of proof. There must be
10 borne in mind that there is no effect on the parties,
11 certainly no immediate effect upon any parties when
making a decision.

12 MR. TOBIAS: In fact, sir, I agree
13 with that. I was going to mention that in a few
14 moments when I get to the comments of Mr. Scott's
15 evidence. I don't think there is any effect on
16 anyone's legal rights and very little prejudice
17 really. There is very little prejudice to particular
18 individuals, given the Court of Appeal decision, but
19 I understand your submission and I think I should
make my submission clearer, therefore.

20 All I am saying is this: there is a
21 range. The balance of probabilities means simply
22 this, and judges do this every day. They take all
23 of the evidence, and to use the analogy of the
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2 scales of justice, they put each piece of evidence
3 on the scales and in the end the scales are either
4 in equilibrium or they tip one way or they tip the
5 other. So that within that range, yes, there is
6 no question that there is a differential in terms
7 of how probable, how probable has it got to be
8 before the scales tip. What I am saying though is
9 this: it would be wrong to make the standard so high
10 that we were beyond the upper range in a balance of
11 probabilities. That is all I am saying to you.
12 It is a fine distinction to draw, but it is a distinction,
13 sir, that you must make.

14 That really leads into my third standard
15 because I would urge upon you is that you must weigh
16 the evidence of all the experts who testified, and
17 this does not mean that you are bound to give all of
18 their evidence equal weight. It is, in my submission
19 sir, perfectly proper to put less stock in certain
20 opinions than in others and we know that judges do
21 that every day, and this is because their expertise
22 is not all the same. Some are expert Commissions,
23 some are expert pathologists, some expert cardiologists
24 and some expert pharmacologists, but that doesn't
25 mean that you should pre-suppose that a pharmacologist



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2 has no cardiac expertise at all and that you should
3 ignore his opinion on cardiac matters. What we
4 suggest is the proper test is that with respect
5 you should weigh that evidence, but give it less
6 weight, however all reasonably qualified opinions
7 should be analysed and examined and put onto the
8 scales and each bit of evidence looked at in that context.
9 Now, to refuse to do so is to fail to recognize
10 that the various sub-specialties in medicine are
11 surely inter-related, that an expert in one
12 specialty surely has some degree of knowledge in other
areas as well.

13 So you can't ignore, for instance
14 Dr. Kauffman, when he talks about cardiac status.
15 An analogy, that I am sure we can all understand in
16 this room is this: you may have a trial lawyer who
17 spends his entire career doing motor vehicle plaintiff's
18 work and he is certainly not an expert in tax law
19 and you certainly wouldn't give him a difficult
20 tax problem to grapple with. That doesn't mean that
21 his opinion, as to basic principles of judicially
22 interpreting the Income Tax Act and the approach
23 today a court would take in interpreting that
24 act and the tests that would have to be met in
25 interpreting that act in court, that doesn't mean his



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2 opinion, with respect to all of that is irrelevant.

3 Lastly, we urge upon you that you
4 should not accept the opinion of any expert, even
5 if that opinion is totally uncontradicted, solely
6 on the basis that he or she is put forth as an expert
7 and knows more about it than you did, because sir,
8 with respect, sir, I would submit that that is an
9 advocacy of your responsibilities and it is perfectly
10 proper for you, and I submit that you must, examine
11 the logical and the scientific basis for the opinion
12 and you must weigh the opinion against this basis
13 before you accept or reject it. You must, in effect,
14 go behind the mere opinion and probe its validity
15 in your own judgement.

16 So the proper way to apply the standards
17 is basically in coming to your conclusion to weigh
18 all of the evidence and the basis the evidence
19 and viewed in tandem with all of the other evidence
20 and all of the other events of the period, to see if
21 on a balance of probabilities you can draw a valid and
22 a judicious conclusion from that evidence.

23 Now, having indicated what we think
24 the proper standards are we simply cannot fail to
25 comment briefly on some of Mr. Scott's argument.

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2 We have already given you our view of this first view,
3 and that is that you should be looking at each death
4 as an unique event. I can put no higher than I did
5 before: to do so would be closing your eyes to
6 reality.

7 With respect to Mr. Scott's second
8 standard. We have, again, given our views in the
9 terms of probability and I think it is important there
10 to note that against the backdrop of the Court of
11 Appeal Decision, no one's legal rights are going to
12 be prejudiced by the report; no one's liberty is going
13 to be jeopardized; no one will suffer public prejudice.
14 All the more reason, sir, why looking where within the
15 range of the balance of probabilities that you should
16 come down. You should not be hearing too much on the
17 side of caution.

18 Mr. Scott also indicated that the only
19 toxicological evidence which can be of any use is from
20 serum or fresh tissue. He said that that is accepted
21 in the cases of Lombardo, Belanger and Hines. But he
22 also urged upon you that that was only proof that at
23 some time during life digoxin could be given and that
24 it couldn't be used, I think his words were, "for any
25 other purpose".

Now, with the greatest of respect to



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2 Mr. Scott, we reject that suggestion. Because if a
3 child dies without adequate explanation and dig. is
4 found in his body when it was not prescribed for him
5 surely, surely, that is supportive of the proposition
6 that on a balance of probabilities the digoxin played
7 some part in the death. And more so if you are not
8 basing your conclusions solely on toxicological data,
9 as suggested to you that the Hines case, certainly,
10 and in a great many of the 36, you wouldn't be basing
11 your opinion solely on toxicological data. You would
12 be looking at the clinical history. You would be
13 looking at what the experts have said about the
14 postulated causes of death. And certainly when you
15 see it as a pattern it is far too narrow that you
16 can only say that the child received some digoxin and
17 you have to stop there, because you are not looking at
18 the toxicology alone.

17 I submit to you that that is precisely
18 where Mr. Scott's argument fails because it presupposes
19 that you are looking at toxicology alone.

20 He also said that if one expert outside
21 the Hospital for Sick Children casts doubt on the
22 intervention of digoxin as a cause, it is unsafe and
23 imprudent to find that digoxin was the cause of death.

24 Now, with great respect, sir, to
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2 Mr. Scott, this goes too far in erring on the side of
3 caution.

4 Surely, if all of the experts outside
5 of the Hospital for Sick Children, but one, argue in
6 favour of digoxin intoxication that establishes a
7 balance of probabilities test. Especially so, with
8 the one expert, has no rational or logical basis for
9 disagreeing, and Mr. Scott's standard simply does not
10 take that into account. And you must, you must -
11 when you look at the expert's evidence, you must also
12 look at the basis. If he merely says, and I perceive
13 this to be his submission, that unless you have
14 unanimity of experts, it is unsafe to draw conclusions.
15 Then I say he goes way too far in the limitations that
16 he would put on you. In fact, he goes almost to the
17 point where he almost destroys your mandate.

18 He also says that you shouldn't reach
19 a conclusion based on subjective observations alone.
20 And he spent a long time dealing really with the words
21 "sudden, unexpected, rapid, irreversible decline" et
22 cetera, et cetera. And he has got a point. That is
23 a subjective standard. That is true. I acknowledge
24 that. But surely that only goes to the weight you
25 give that evidence. Surely, you shouldn't be simply
ignoring it. Its probative value has to be weighed and



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2 determined. And, again, you don't look at it in a
3 vacuum. You put that on the scales along with all of
4 the other evidence.

5 Now, Mr. Scott in particular found
6 objectionable Mr. Lamek's observations on the common
7 threads - on the pattern - and his argument was
8 extremely clever. What he is saying is that the
9 findings have to establish the pattern, the pattern
can't establish the findings.

10 Now, in deference to him, notwith-
11 standing the fact that it is such a clever argument --
12 in fact, it is so clever that I am envious -- but even
13 if I had thought of it I couldn't use it anyway. Not
14 in the scope of my retainer. In the end it must fail
15 and it must fail because it doesn't take into account
16 one inescapable fact, and that is regardless of my
17 friend's view that there is uncontroverted evidence,
18 sir, that establishes that there was a certain pattern
19 to these deaths. A pattern that is there regardless
20 of what findings you may make or how you may choose
21 to utilize the presence of the pattern in coming to
22 your conclusions. And it may be uncomfortable, its
23 presence. It may not be to the liking of some of us,
24 it may be embarrassing to some of us, but we cannot
25 just simply make it go away by closing our eyes to it.



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2 Surely, the fact that there is this
3 common thread presence lends a degree of suspicion
4 and probability to certain cases. I don't suggest,
5 sir, not for a moment, that that alone is sufficient
6 to allow you to draw a conclusion. You should not do
7 that solely on the basis of this common thread, but it
8 is certainly, again, one of the things that you look
9 at in constructing your conclusions, if I may, out of
a series of building blocks.

10 You see, some cases there is the
11 smoking gun. There is that one uncontroverted piece
12 of evidence which you see on the Bench. I suppose
13 you don't say it to the litigants, but when you hear
14 it you say, well, that they just can't get around
15 that. But this is not that kind of a case. This is
16 a case where, really, the conclusion that you come
17 to has to be built on a whole series of building
18 blocks, as it were. To ignore the pattern is to make
it impossible for you to construct that conclusion.

19 Now, Mr. Scott made an analogy of his
20 argument to a motor vehicle trial. He said you surely
21 can't ask the defendant, "Have you ever been involved
22 in other accidents?". Now, I submit to you that the
23 reason why you can't ask that question is not because
24 the question is one without logic, but because the
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2 logic is so weak and its probative value so low that
3 it is outweighed by the prejudice that it may indeed
4 cause.

5 However, that is because the events
6 under inquiry at a motor vehicle trial - that is, that
7 particular instant motor vehicle accident as against
8 the other motor vehicle accident - are distinctly
9 separate and different events with little or no
10 connection and this is not the situation in this case.

11 Here, the events are intricately inter-
12 connected and inter-related because all of these
13 babies died on the same ward, in the same hospital,
14 at the same time of day, in the presence of the same
15 personnel, under very similar circumstances, and all
16 within the same epidemic period.

17 Now, where there is that kind of
18 similarity of events, the similarity surely is
19 relevant because of the inter-relation of events such
20 as here. And such evidence, I submit to you, is
21 entirely admissible and quite probative. That is
22 exactly why in our system of justice there is
23 provision for the introduction of similar fact evidence.
24 So, what you are looking at is "Are they connected?".
25 If they are not connected, well then, okay, it is too
prejudicial. Prejudice outweighs the probative value.



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2 I suggest to you that is not the case, sir.

3 Mr. Scott also says that with respect
4 to the Center for Disease Control Report, it is only
5 useful to show you that there was an increased
6 incidence of death and that is the only use that you
7 can make of it. But, I submit to you that it is also
8 useful with respect to the conclusions drawn by the
9 consultant experts with respect to their findings in
10 regard to these children. Surely, Dr. Kauffman,
11 Dr. deSa, Dr. Nadas, all of those doctors' evidence
12 is relevant and useful and it does form part of that
report and, surely, you should give it proper weight.

13 Mr. Scott also said that if a
14 pathologist, given his scientific focus and purpose,
15 can't find a cause of death that there is nothing
16 suspicious about that.

17 Well, there may not be, if that fact
18 alone is taken in isolation, but where there is any
19 evidence - any evidence at all - of foul play, as
20 there is here, and a cause of death can't be
21 determined by the pathologist, surely the index of
22 suspicion must go up. And that is the only real use
23 that you can make of that evidence and I would think
24 that it is logical to say that the more evidence of
25 foul play there is, on the one hand, the more pieces



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2 of evidence that you have in the scales of favour of
3 foul play, then the more reliable and convincing that
4 evidence is, then the higher the index of suspicion
5 gets, in the absence of pathological findings to
6 explain the death naturally. One follows upon the
7 other.

8 Lastly, I want to deal with Mr. Scott
9 suggested you would want to do in publishing this
10 report.

11 He says that where you are not certain
12 with a reasonable level of assurance, you should say
13 so and you should leave it there. He says you are
14 not required nor can you reach conclusions in each
15 case; that you were not appointed to engage in further
16 speculation and suspicion, particularly since this is
17 a matter of about which there has already been far too
18 much speculation and suspicion.

19 Now, again, with respect to my learned
20 friend; I submit that this view was wrong. Mr. Scott
21 used an analogy of a trial where the plaintiff's case
22 fails because he has not discharged the burden of
23 proof. This, however, sir, is not a trial. It is
24 a commission of inquiry - underlining the word inquiry -
25 and you, sir, are appointed not only to inquire, but
in the very words of the Terms of Reference, "To report



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2 on how and by what means these children came to their
3 deaths". If you simply say "I don't know. I don't know.
4 I don't know. I don't know", that is not much of a
5 report, I am afraid.

6 I must adopt Mr. Labow's submissions
7 of yesterday with respect to the anguish suffered by
8 the parents over the last three to four years and with
9 respect to you being their last hope.

10 I will go further than that. I will
11 go much further than that. Surely, there are people
12 who did not lose children at the Hospital for Sick
13 Children but who have had to take their child to that
14 hospital who have also suffered anguish. I can't
15 believe that there aren't, daily, people that are
16 being just that extra little bit more cautious. Maybe
17 they are staying there overnight when they wouldn't
18 have been before. Maybe they have got a level of
19 anxiety that wouldn't be there but for these tragic
20 events.

21 Now, you were appointed because the
22 Lieutenant Governor in Council wanted the parents in
23 particular and the public as a whole to have the
24 benefit of your opinion, even if the hospital, itself,
25 didn't want the benefit of your opinion. You were
appointed because it is a matter of such grave



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2 consequence that a judicial, well reasoned, fair and
3 impartial opinion must be given because, at best, you
4 can, sir, under the circumstances, must answer the
5 questions even if they are not definitive answers.
6 And it may well be that Mr. Scott is right in that
7 point that you can't give a definitive answer, but I
8 see nothing wrong with you giving your opinion. I
9 think that is what you were appointed to do.

10 Mr. Scott says that if you are not sure,
11 how will the parents and the public be served by your
12 opinions and suspicions? Well, they will be served
13 because your opinion will be the most definitive one
14 possible under the circumstances and it will be given
15 by one of our most eminent and most respected jurists;
16 and the opinion that comes out after a painstaking
17 and open inquiry that has engaged you for over a year.
18 And with the greatest respect, I submit that Mr. Scott
19 fails to realize this. He fails to realize that
20 neither the hospital, neither the parents or the public
21 would be served by the publication of a report that
22 said nothing; that didn't draw a conclusion; didn't
23 give opinions. And the report, lastly, I take it will -
24 I shouldn't say "I take it" - it is obvious that this
25 report will not be the mere musings of the man on the
street that has been watching these proceedings on his



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television set every night when he had insomnia. I

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think the public will be well served by being given

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the benefit of your opinion and your judgment.

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To put it colloquially regardless of how much Mr. Scott and his clients might hope otherwise there are certain questions here that he just can't duck. They have got to be dealt with.

I have some very brief comments regarding Mr. Scott's written submissions with respect to Hines. That is at Tab 29 of this prepared material.

The impression is given I am sure by error in that document that the levels obtained in the Hines case were on exhumed tissue. Now it may not be a critical distinction, but I think it is fair to note that the readings found in heart which Dr. Hastreiter and Dr. Kauffman placed a great deal of reliance on was on fixed heart tissue.

Now that will be important when you come to consider how Mr. Cimbura did his estimates of what would have been in the fresh tissue. I suggest to you, sir, I submit to you, sir, that that estimate is far more reliable when it comes to fixed tissue than with respect to --

THE COMMISSIONER: Will you just give me the precise part that --

MR. TOBIAS: Yes, I think it is on --

THE COMMISSIONER: The heart tissue,



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that is fixed, is it?

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MR. TOBIAS: Yes. Are you looking for
the page reference in Mr. Scott's volume?

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THE COMMISSIONER: Yes. It is Page 5.
Heart Tissue -

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7

MR. TOBIAS: Well, Page 5, Pathological
Data.

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THE COMMISSIONER: He doesn't say it
was exhumed, does he?

10

MR. TOBIAS: I believe he did.

11

THE COMMISSIONER: The heart?

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MR. TOBIAS: Yes.

13

14

"Nonetheless upon exhumation of this
child's body digoxin was found in his
tissues."

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16

That is the comment I am referring to.
That is on Page 1 of the Summary.

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THE COMMISSIONER: Will you say that
again?

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MR. TOBIAS: In the third paragraph,
sir, second sentence:

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"Nonetheless upon exhumation of this
child's body digoxin was found in his
tissues."

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We know that in fact -- well, in

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fairness the readings were first found in the heart tissue and it was only after those readings came out that an order for exhumation was made. That has always been my understanding of the sequence of events. I believe that is borne out in Exhibit 95 A.

THE COMMISSIONER: Well, that doesn't matter. The heart was preserved.

MR. TOBIAS: Yes, that is correct.

THE COMMISSIONER: In some solution.

MR. TOBIAS: That is correct, and then following those levels an order for an exhumation was made, the body was exhumed and levels were also run on exhumed liver tissue and thigh tissue.

THE COMMISSIONER: Only the heart tissue that was fixed, is it?

MR. TOBIAS: That is my information, sir.

MS. CRONK: No, there was a specimen of fixed lung tissue as well, sir.

MR. TOBIAS: Yes. I am grateful to my friend. That is also correct. It is really the last paragraph --

THE COMMISSIONER: That is fixed.

MR. TOBIAS: Yes, and it is really the last paragraph on Mr. Scott's written submission that



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-4 2 bothers me the most and causes me the most concern.

3 He says:

4 "The digoxin readings on this child
5 come from exhumed tissues and therefore
6 are not felt to be quantitatively
7 reliable."

8 Then of course the same statement I suppose can be
9 made of fixed tissues, but I think it is important
10 to note with respect to the heart and lung they were
11 fixed.

12 THE COMMISSIONER: Yes. All right.

13 MR. TOBIAS: Now with respect to the
14 particular evidence concerning Jordan Hines, in the
15 first instance I adopt Mr. Lamek's argument that
16 the only really two contenders here in the final
17 analysis are digoxin intoxication or sudden infant
18 death syndrome, and he summarized in his argument
19 the basic SIDS view. And it is in essence Dr. Becker's
20 findings and his opinion as expressed in the autopsy
21 report and the digoxin intoxication is based essentially
22 on the findings of digoxin in tissues although the
23 child was not prescribed for it.

24 He also reverted to the evidence of
25 Drs. DeSa, Kauffman, Hastreiter, and Mirkin to the



1
2 effect that SIDS is inappropriate because it is a
3 diagnosis of exclusion, and toxicology was not
4 excluded, that there was preexisting illness and that
5 there was the presence of the drug in the tissues,
6 and he said due to the manner of his death and that
7 evidence, the nature and suddenness of the terminal
8 events, the unexpectedness of death, the lack of any
9 explanation until the SIDS argument surfaced, that
10 you should find that death was due to digoxin intox-
11 ication, and I adopt that submission.

12 I also wish to adopt Mr. Lamek's
13 submissions with respect to the relevance of the
14 Cook case, and what you can draw, what inferences
15 you can draw from that case in the event that you
16 find that the Cook death was due to digoxin intoxication.

17 I also adopt his submissions with
18 respect to what use you could make out of
19 the patterns and the common thread that runs
20 throughout the deaths and I adopt Miss Cronk's
21 submission with respect to the digoxin data which
22 I think were extremely fairly and accurately summar-
23 ized.

24 Now in the Hines case specifically -
25 Mr. Commissioner, I'm just wondering if this might



1
2 be an appropriate time.

3 THE COMMISSIONER: Yes, all right.
4 We'll take twenty mintes.

5 --- Short recess.

6 --- Upon resuming

7 THE COMMISSIONER: Yes, Mr. Tobias.

8 MR. TOBIAS: Yes. Mr. Commissioner,
9 it might be helpful if I simply point out one thing.
10 I am now about to begin a review of the evidence and
11 the various opinions.

12 I can tell you I won't be making any
13 submission to you whatsoever that is not in the
14 written argument. The references are set out in the
15 written argument in a great amount of detail.

16 I would like to begin by looking at
17 this child's clinical course in the Hospital. The
18 basic data is set out in writing for you, and you
19 heard the evidence of Mrs. Hines with respect to her
20 observations of her child. I will not repeat those,
21 but they are all set out in the first four pages of
22 the argument.

23 Dr. Kobayashi testified before this
24 Commission that on admission there were no periods
25 of apnea observed and on morning rounds on Friday,
March 6, there was no concern with the child at all.



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He also gave evidence that in the early morning of Saturday, March 7, 1981, there were no symptoms noted and on checking with the nursing staff he had been informed by them that no apneas or bradycardias were observed over the course of the Friday night to Saturday morning nursing shift.

His own words as Mr. Lamek pointed out were that on the Saturday morning the child was "extremely stable".

It was Dr. Kobayashi you will recall who saw the child several more times on that Saturday, and again made enquiries of the nurses, and again throughout the course of the day on Saturday was told there were no periods of apnea or bradycardia noted.

He again saw the child in between one o'clock and two o'clock in the morning on Sunday, March 8th, and by a process of elimination in reading the chart it appears that that was the last time any of the resident doctors saw the child before the terminal events, and again he stressed that at that time there had been no noted periods of apnea or bradycardia from the time earlier in the day that he had inquired and that he had no concern for the child who seemed to be responding to medication and improving.



1

2

Now, it is I think relevant to note

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because so much has been made in this Commission out

4

of observed documented, and I underline those two

5

words, observed documented, periods of apnea.. This

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child was in the Hospital for 48 hours. There is

7

no reference anywhere in the medical record that the

8

apnea monitor went off at any time prior to the onset
of terminal events.

9

Dr. Bain agreed with me that you set

10

the apnea monitor for a certain time span, the

11

implication clearly being that if you have an apnea

12

under that setting you are not concerned about it;

13

it is not significant, you don't want the warning

14

to go off.

15

Now it is also fair to note that there

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are very few references in the medical chart which

17

is Exhibit 103 to observed periods of apnea. There

18

is one I grant you on Page 81 of the medical record

19

which was a nursing note by Cannon, RNA, "Apnea,

20

tach & brady, quite hard to arouse when he came in.

21

Eyes crusty", but that note was made at 2430 on

22

March 5, 1981. In fact it was made I think it is a

23

reasonable inference, at 12:30 on March 6 and we know

24

that is when the child first came up to the floor.

25

F-8



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2 So I submit to you that it is not an actual observation
3 of apnea but a noting by the nurse of what was on
4 the admission sheet in terms of history.

5 Now that is the same note that appears
6 earlier on in the progress notes by Cannon at Page 33,
7 5/3/81, and then she notes apnea. That is clearly
8 the same note. The only other reference in the chart
9 itself is March 6, 1981, and evidence has been given
10 by Dr. Kobayashi that that doesn't appear to be a
11 note of a nurse but of a doctor. We don't know
12 unfortunately who made that note.

13 He postulated it might have been Drs.
14 Mangaro or Soulioti but he wasn't sure. He couldn't
15 identify the handwriting, and what we don't know
16 and may never know is whether or not that "still
17 having apnea" means that the doctor actually saw the
18 apnea or was informed by some of the staff.

19 What we do know is that Dr. Kobayashi
20 himself who was looking in on the baby certainly was
21 not informed.

22 Now the only other references to apneas
23 are the admission notes which appear at Pages 58 to 62
24 of the medical record which are based primarily on the
25 notes, on the notes from North York General Hospital
and the mother's history and the observations that the



EMT/pg
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mother gave to people at the North York General Hospital regarding the episodes described at home. But we do have a luxury, sir. The luxury that we have is that we called the mother as a witness. She gave her evidence. She told you what happened at home, and it is that that you should be paying attention to, not notes made by some third party on the basis of what she said to a fourth party on the chart.

Now we also know that the nursing note of Nurse Reaper that Mr. Lamek refers to which is at Page 35 of the record indicates that during the long night nursing shift of March 7 and 8 there was no distress in the child and no noted observations of apnea or bradycardia.

I suggest to you, sir, it is a fair inference from that that there were none because had there been she certainly would have noted it. Evidence has been given before this Commission, particularly by Dr. Bain, that the whole purpose of progress notes are for the nurses to note things of significance. Those would have been things of significance. The fact that they are not there allows you to infer they didn't happen.

We also have the notes of Miss Lyons and Janet Brownless which appear on Page 34.



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Now I make the same submission there.

3

If Miss Lyons saw periods of apnea and bradycardia

4

I submit she would have noted that, and she did not.

5

Janet Brownless we know did not and

6

we heard from her. She testified that she had seen

7

the child on Saturday afternoon and had spent most

8

of Saturday afternoon with the child and saw no

9

periods of apnea or bradycardia on that day.

10

We also have before us Exhibit 360

11

which was the Tour End Reports, and in particular

12

the Tour End Reports for March 7, 1981, indicate

13

that the child was stable with no periods of brady-
cardia or apnea.

14

There has also been evidence given

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to this Commission by all of the witnesses, but in

16

particular I rely on the evidence of Drs. Rowe and

17

Rose that this child's terminal events came on

18

suddenly and unexpectedly and were rapid and irrevers-
ible.

19

Dr. Costigan who was present at the

20

arrest, Dr. Fowler who is a cardiologist of eminent

21

standing, and Dr. Rowe, all indicated that part of the

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terminal events seen in this child were ventricular

23

fibrillation and in particular they all noted that

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that was most unusual.

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Dr. Costigan's evidence you will recall which appears at Volume 45, Page 106, lines 9 to 21, is that he was quite surprised by the exhibiting of ventricular fibrillation as part of the very initial stages of the cardiac arrest. He would not have been concerned had he seen them toward the end.



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RD/hr

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Now, in looking what I suggest to you, after you have looked at the clinical history and the observations of the mother and the basic data, is the various possibilities.

Now, other than digoxin intoxication which Dr. Rowe said was a possibility, subject to the pharmacological debate, he said that the possibilities that were entertained originally were as follows. I shouldn't say that. His evidence wasn't that all of these possibilities were entertained originally. What he said is that over the course of the entire event and by that I mean cardiac arrest to the time that he came here to give his evidence, the following had been postulated: sudden infant death syndrome, viral infection of the heart, conduction problems, which I will be submitting to you, Dr. Rowe gave direct evidence that we can use, conduction problems and sick sinus syndrome interchanging. They are one of the same. Cardiac tumor, sepsis or pneumonia. Subsequently, viral infection of the heart muscle, cardiac tumor and pneumonia, were successfully ruled out, leaving as possibilities sudden infant death syndrome, sick sinus syndrome or dig. intoxication.

Dr. Fowler also was asked the same



G-2

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2 question and he listed four possibilities: sick
3 sinus syndrome, digoxin intoxication, sudden infant
4 death syndrome all possibilities postulated by Dr.
5 Rowe and he threw out hypothetically that it might
6 be some other entirely unknown and undetected cause
7 which we haven't even identified yet.

8 We know what Dr. Rose's initial thought
9 was, Dr. Vera Rose, and that was myocardial infection.
10 She agrees with the other doctors that sudden infant
11 death syndrome conduction problems and digoxin
12 intoxication are still contenders. We also know
13 that when the child was discharged from North York
14 General Hospital, and we know this because we filed
15 as Exhibit 410 the final discharge summary, that
16 their working diagnosis at that time was one of sick
17 sinus syndrome with bradycardia and tachycardia
18 "probably due to some form of congenital heart disease."

19 There had been evidence at North
20 York General Hospital of some abnormality in the heart
21 muscle or the conduction system and further evidence
22 though, that the child was developing a degree of
23 myocardial failure, and particular, the discending
24 of the liver and other signs that he was going into
25 heart failure and that is precisely why Dr. Shams
saw fit to telephone Mrs. Hines at 9:45 on March 5th,



1
2 to indicate that the child had to be transferred, not
3 the next day or the day after, but right then and
4 there, so obviously he was concerned and we know
5 what his concern was, it was conduction problems
6 due to congenital heart disease.

7 The other possibility that was thrown
8 out by Drs. Hastreiter and Kauffman was that the
9 child -- not the other, but they confirmed rather,
10 that the child was suffering from conduction problems
11 or sick sinus syndrome.

12 We know and we have heard evidence over
13 and over and over and over again ad nauseum that this
14 child is one of the four who had digoxin in his tissues
15 and was not prescribed digoxin.

16 We come then to having canvassed all the
17 various possibilities, what were the opinions of
18 the doctors when they were here before us? Well,
19 Dr. Rowe, Dr. Fowler and Dr. Rose adopted what
20 I like to refer to, tongue in cheek, as the hospital
21 line. That was that although they didn't know the
22 cause of death initially, and although they all
23 admitted that digoxin intoxication was a possibility,
24 subject to the pharmacologic debate, that they
25 subsequently, at some point in time, came to accept
Dr. Becker's diagnosis of missed sudden infant death



G-4

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2 syndrome and Dr. Rowe, Dr. Fowler and Dr. Rose were
3 all very clear that they were greatly influenced
4 in adopting that view by Dr. Bain's Report.

5 So it was a combination of reliance
6 on the pathological expertise of Dr. Becker in
7 conjunction and in tandem with the opinion of Dr.
8 Bain who they all regarded very highly.

9 Dr. Becker obviously is in the
10 sudden infant death syndrome camp, but even he says
11 somewhat reluctantly, but he does say, and the references
12 are there in our written argument at the bottom of
13 page 12, subject to the pharmacological debate there
14 is, and I quote: "no question that the pathological
15 diagnosis is one of missed-SIDS" and Dr. Bain shares
16 that opinion. He says that the child certainly
17 quote ... "certainly had missed-SIDS and may have
18 had SIDS again subject to the pharmacological debate".

19 On the other side we have the evidence
20 of Dr. Hastreiter and Dr. Kauffman that there was
21 a high probability of digoxin toxicity and I don't
22 think we should glibly just gloss over those words.
23 They are not talking about high possibility. These
24 are men of science and they adopt their words very
25 very cautiously and I am struck by the use of the
words, "probability, high probability".



G-5

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2 This case to them respresented a case
3 of "probable murder" and Dr. Hastreiter said that
4 if you leave the digoxin out of the equation, if you
5 ignore it, his diagnosis would not be sudden infant
6 death syndrome but sick sinus syndrome.

7 Basically the opinions of Drs. Hastreiter
8 and Kauffman were confirmed by the opinions of
9 Drs. Mirkin and Fay. They used different words, but
10 they were all basically saying the same thing.
11 Mirkin used the words high index of suspicion and
12 Fay said that the cause of death was likely digoxin
13 intoxication and he has well voted for the probable
14 murder category.

15 I think it is important, I think it
16 is vital in your deliberations to look very carefully
17 at Dr. DeSa's report. He is, as you know, sir, is
18 the consultant pathologist for the Atlanta Report
19 and he specifically rejected the sudden infant death
20 syndrome diagnosis, finding that this was one of the
21 cases where the autopsy results "did not adequately
22 explain the cause of death". He felt that digoxin
23 may have been a contributing factor. This is the
24 Chief of Pathology at Winnipeg Children's Hospital.

25 Lastly, I would like to refer to Dr.
Nadas. He also gave his opinion and his opinion was,



G-6

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2 and this is contained in the Atlanta Report, that the
3 timing of death was "expected and consistent with
4 clinical status and the mode of death was inconsistent
5 with digoxin intoxication."

6 In fairness, however, Dr. Nadas'
7 review was based solely on the chart review and that
8 was based on a specific ignoring of an exclusion of
9 the dig. data.

10 I am painfully aware of the fact that
11 sauce for the goose is sauce for the gander. Here
12 I am saying that Dr. Nadas only reviewed the chart.
13 What about Dr. DeSa. What did he do? What he did, sir
14 was absolutely identical in every respect to what
15 Dr. Becker did. He came to Toronto, sat down in
16 the Hospital and this is all in Exhibit 283 of his
17 report, and he actually saw and studied under a
18 microscope the microscopic slides, so he actually
19 saw the raw data that the Becker opinion was based
20 upon and came to a different conclusion that is far
21 superior, I think you must agree, on a logical basis,
22 to a simple chart review.

23 Now, we have covered, as I suggested
24 you do when you break this case down, all of the
25 opinions postulated at any time and how they finally
crystalized in the case of each doctor.



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2 I would now like to look specifically
3 at SIDS and I would like to look after that specifically
4 at digoxin and then I would like to deal with Sick
5 Sinus Syndrome.

6 Dr. Becker testified, and this appeared
7 at Volume 38, page 7584, line 16, to page 7592,
8 line 24, that missed sudden infant death syndrome
9 is death due to sudden infant death with one or
10 more previous episodes of apnea or missed sudden
11 infant death syndrome during life. Sudden infant
12 death is on the other hand death due to sudden infant
13 death where there were no previous periods of apnea
or missed SIDS during life.

14 Notwithstanding the fact that I did
15 my level best, assisted very ably by Miss Cronk,
16 to totally confuse that issue back in October -
17 Miss Cronk is looking at me - I mean that only in
18 a complimentary sense. I think it is an easy and
19 clear distinction that once you dilute the evidence.
20 I was reading with some degree of humour, I suppose,
21 the other day that Volume where Dr. Becker gave
22 that evidence and, you know, you had it nailed down,
23 Mr. Commissioner, about six times and then I would
24 ask another question and muddy the waters and you
25 finally told me: "Look, Mr. Tobias, I have it and



G-8

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just don't ask anymore questions on it, I understand
it; leave it alone."

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Now, Dr. Becker's evidence, in effect,
should be looked at, I submit very carefully, in
respect of two things, because this is the guts of
the sudden infant death syndrome problem. You have
to look at the significance of the presence of those
four pathological markers and apnea and you have to
look at the presence of arrhythmias.

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Let's deal first with the four
pathological markers in the apnea. As you know, Dr.
Becker gave evidence that there were various
indicia of sudden infant death syndrome confirmed
and unconfirmed, confirmed being at least two reports
in literature and unconfirmed being only one report
in the literature. You said there were four
confirmed changes. I am sure, sir, you have this
memorized already, but at the risk of offending you,
I will repeat them: brain stem astrogliosis, which
is scarring of the brain stem; extra-medullary
hematopoiesis, which is the production of red blood
cells outside of the bone marrow; thickening of the
pulmonary arterioles and preservation of brown fetal
fat.

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He said that in arriving at a terminal



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2 diagnosis of missed sudden infant death syndrome
3 that he would rely on the presence of one or more of
4 those four pathological changes in combination with
5 observed and documented periods of apnea during
6 life. His view was very, very vociferous and
7 unbending that if those four markers were there,
8 as well as periods of apnea, it was not consistent
9 with any other pathological diagnosis, but missed
10 sudden infant death syndrome.

11 It was the evidence of Dr. Bain on
12 that point that the four pathological changes seen
13 at autopsy, which are suggestive of SIDS , are
14 subtle changes. He used the word, "subtle" and Dr.
15 DeSa used the word, "subtle" and I recognize Dr.
16 Kobayashi is hardly an expert in this area, but he
17 also used the word, "subtle" and I will deal with
18 that at greater length in a moment.

19 Bain's evidence, though, was that they
20 were subtle changes and he also admitted to you,
21 and this was in direct response to a question by
22 you, that if a child had experienced periods of
23 apnea during life, thus producing hypoxia and thus
24 producing the four changes, but had died from some
25 thing else entirely, from a gun shot wound to the
head, let's say for argument sake, then you would



1
2 see the four changes at autopsy even though the
3 cause wouldn't be sudden infant death syndrome.
4 That is a logical proposition that was put to Dr.
5 Becker by Miss Cronk, by myself and by yourself,
6 but his admission to that was far more tentative
7 than Dr. Bains. Dr. Bains said, yes, that is
8 quite logical that it would happen.

9 The evidence of Dr. Rose in connection
10 with SIDS in the indicia are that apnea, coughing,
11 bradycardia and tachycardia are not specifically
12 SIDS, but they can be explained by other factors.
13 She gave no evidence with respect to the significance
14 of the pathological factors, because she is not a
15 pathologist.

16 Now again, my analogy this morning'
17 of a trial lawyer who is asked about general questions
18 about tax law. Well, Dr. Kobayashi went to school
19 and Dr. Kobayashi took lectures and Dr. Kobayashi
20 did his training and clearly Dr. Kobayashi understands
21 how a pathologist studies slides and he understands
22 what the procedure is for fixing them and how you
23 put them under a microscope and you read certain changes
24 and I don't rely on anything that he may have said
25 with respect to the presence of the four changes
except this, and this you can draw upon because



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he doesn't have to be an expert in SIDS to know this. Knowing what the procedure is his evidence are that the changes, which are seen, are subtle changes, therefore, they are subject to interpretation in this sense, and this specific scenario was put to him because I wanted him to explain to me what he meant by subtle and that is that two pathologists could study the same slide. One would see the changes and would confirm the presence and the other might not because it is a question of interpretation. They don't jump out of the microscope at you.

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I would like to deal with the evidence of Dr. DeSa because the evidence of Dr. DeSa, sir, I submit to you, is in direct contravention of the evidence or contradiction, rather, of the evidence of Dr. Becker. His evidence, in no uncertain terms, was that the pathological findings not only didn't explain the cause of death in this case, but that opinion was made without reference to digoxin data and after a complete study of the reports and the microscopic slides itself. That is Exhibit 283. He set out his methodology at what is page 2 of that report. I will just quote it to you. I don't think you need the exhibit in front of you.

24

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"I was asked to assess the 41 autopsies



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respect to 1., the nature and severity
of disease and, 2. whether or not
there was a reasonable anatomical
cause of death."

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This is the part that I am relying on, 3:

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"I was to review the digoxin data
on the 41 cases after completing
one and two above."

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2 More importantly, Dr. deSa states - and he is an
3 expert pathologist - that the changes seen are:

4 "very subtle and are not specific
5 to sudden infant death syndrome but
6 could result from chronic hypoxia."

7 His evidence was in effect that since
8 "has no specific morphological features." And Dr.
9 Hastreiter was asked to give his opinion with respect
10 to the same issue and he confirmed that they are
11 not specific to SIDS, those four pathological markers,
12 but can be caused by other conditions. In particular
13 he took brainstem astrogliosis. He indicated that can
14 be found in children that have chronic hypoxia which
15 can be caused by a number of factors, such as
16 rhythm problems. And that evidence, sir, in my
17 submission, is critical. We know this child had
18 rhythm problems.

19 I will be referring to you later,
20 when I deal with sick sinus syndrome, of uncontroverted
21 evidence by all experts, inside and outside of the
22 Hospital. No question, rhythm problems can lead to
23 hypoxia and in turn can lead to these changes seen
24 at autopsy.

25 He also said - and if I go back now
to Dr. Hastreiter - that extra-medullary hematopoiesis



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H-2 2 can also be seen in neonates, which Jordan Hines was.
3 Nothing specific to SIDS about that.. And is often
4 due to hypoxia.

5 Dr. Kauffman, as well, testified that
6 the findings seen at autopsy are not specific. He
7 also confirmed that extra-medullary hematopoiesis
8 is not specific to SIDS but is common in newborns and
9 is a carry over from fetal life. And that brainstem
10 astrogliosis can be seen by a number of other
factors including hypoxia.

11 Most importantly, much was made of the
12 apnea. You have Dr. Kauffman cautioning very carefully
13 Mr. Strathy not to equate - and this is in Mr. Strathy's
14 cross-examination - not to equate apnea with SIDS.
15 He states that apnea is not specific to that syndrome
16 but maybe caused, especially in neonates, by a great
number of factors.

17 Now, what about the question of the
18 arrhythmias? As well, Dr. Rowe certainly has to be
19 looked at in connection with this question because
20 his speciality is cardiology, but he can only go this
21 far. He says that arrhythmias can be seen with SIDS.
22 However, you can't say with confidence unless you see
23 a rhythm strip, in Hines, the arrhythmias that he
24 suffered is part of the terminal events were consistent
25



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2 with those sometimes. And he stressed the words
3 "sometimes seen."

4 Dr. Fowler's evidence went much
5 further. He said that arrhythmias are fairly rare
6 in cases of sudden infant death syndrome. They are
7 usually marked by a prolong QT interval. And if you
8 recall I put that chart to the doctor, and the zebra
9 pack, asked him to study all the rhythm strips and
10 he confirmed, as Dr. Rose, that there was no evidence
11 in those rhythm strips of a prolonged QT interval.

12 Dr. Rose also indicated that the
13 support for the views that Dr. Fowler had given and
14 that is that the appearance of apnea and bradycardia,
15 bradycardia being an arrhythmia, are suggestive of
16 sudden infant death syndrome. They are not inconsistent
17 with it. But it can be suggestive of other things
18 as well.

19 Then we come to Dr. Becker's evidence.
20 This, again, is a critical area.

21 Now, he says that bradycardia is
22 commonly seen in a sudden infant death syndrome
23 situation, however, tachycardia less so. His apnea
24 hypothesis, however, accounted for this. And I would
25 like to look now at his apnea hypothesis.

As I understood his evidence -- and



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2 I would indicate to you that this is dealt with
3 extensively, sir, in Volume 38, Page 66 - sorry - 7668,
4 line 9, through 7669, line 8, and again, at Pages
5 7672, line 16 to 7673, line 4.

6 His hypothesis is as follows. There
7 is abnormal neurocontrol in the brain which controls
8 respiration ... and cardiac functions, as well. And
9 it is this abnormal neurocontrol which counts, not
10 only for the apnea and bradycardia which are commonly
11 seen, but for the tachycardia as well, which is less
commonly seen.

12 And he says in support of that that
13 you have brainstem scarring in the very region of the
14 brainstem which controls this function. He then
15 indicated that he wanted to do a conduction study
16 because if he could show that the conduction system
17 was normal and therefore the apnea hypothesis -
18 sorry-if he could show that it was normal and therefore
19 tachycardia was not accounted for by sick sinus
20 syndrome, or conduction problems, then that would
21 enhance his hypothesis that the apnea hypothesis
accounted for tachycardia and the tachycardia was not
due to conduction problems.

22 Now, Dr. Hastreiter pointed out that
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the problem with Dr. Becker's apnea hypothesis is that it can't conclusively account for the periods of tachycardia because it is only a theory, it is only a hypothesis, and still has to be proven.

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In particular, he noted that no conduction study was done so you can't rule out conduction problems. You can't, therefore, say that the tachycardia wasn't due to conduction problems and in the light of that lack of evidence to rule that out. There is still no proof of the correlation between neuro control and tachycardia.

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He also testified, as well, that in this particular case bradycardia preceded the apnea in the terminal events. And given Dr. Becker's hypothesis this should be seen the other way around.

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Now, I would like to add to that even without Dr. Hastreiter's very, very damning qualifications, it is a quantum leap, in my view, in logic to say that because there is scarring in a particular area of the brain which can control both functions, and because there is no hard evidence of conduction problems, it is a quantum leap in logic to get the lab evidence to say, "well, that proves that it's got to be due to the abnormal neuro control." I don't think Dr. Becker went that far, nor do I think



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1 he would.

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3 Dr. Bain gave evidence and he was
4 extremely clear that arrhythmias are often seen with
5 sudden infant death syndrome. However, you must look
6 at Dr. Becker's evidence in light of Dr. Hastreiter's
7 evidence which contains, I submit to you, a very
8 critical point because not only did he criticise
9 Dr. Becker's hypothesis as a yet unproven theory,
10 but he pointed out quite frankly that sudden infant
11 death syndrome, for the sake of argument, may possibly
12 count for the presence of arrhythmia seen in the
13 terminal events. So, he is saying "even if I concede
14 that, how do you account for the presence of these
15 arrhythmias in the days preceding the terminal
16 events? How do you account for the fact that they
17 were there before when the child was in the North
18 York General Hospital?" And that is why he rejected
19 sudden infant death syndrome.

20 He then went further. He said not only
21 is it just a history of arrhythmia but the types of
22 arrhythmias, as well. Which is consistent with SIDS
23 theory.

24 Now, you will recall that Dr. Hastreiter
25 was asked again to examine the zebra packs and his
evidence was as follows. He had an undated rhythm



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2 strip and he said to me - he gave me an important
3 qualification. He said, "Mr. Tobias, if we later
4 find out that this rhythm strip was taken at the
5 terminal events then forget everything I'm about to
6 say." Not relevant. "But on the basis of this
7 rhythm strip, absent that possibility that it was
8 part of the terminal events, what it shows is that
9 the bradycardia - tachycardia is not originating
10 in the sinus node, but outside of it. And what this
11 amounts to is a real arrhythmia, not just an
12 acceleration of the beats in the sinus node."

13 Now, the relevance of that evidence
14 is that that is yet another piece of evidence which
15 is hard, objective evidence of problems in the
16 conduction system. If he had problems in the conduction
17 system which might explain that it makes the diagnosis
18 of sudden infant death syndrome inappropriate.

19 Dr. Mirkin is on Dr. Kauffman's and
20 Dr. Hastreiter's side. He says that arrhythmias,
21 that ventricular tachycardia and ventricular fibril-
22 lations are uncommon of SIDS. Which I would submit
23 to you that on the weight of the evidence - all of the
24 evidence - that it is clear that you can't conclusively
25 find that SIDS has specific pathological indicators.
That is subject to great debate. It is resisted by Dr.



1
2 deSa. He rejects it out of hand, so you can take
3 no comfort from the presentation of these indications
4 at autopsy.

5 If you accept that, then SIDS has to
6 fall because so much was pinned upon that by the
7 Hospital.

8 I also submit to you that on the weight
9 of the evidence - and particularly this is why I said
10 to you before, look at the basis for the evidence.

11 Now, everything that Dr. Hastreiter
12 and Kauffman has said about the pre-existing illness
13 about the kinds of arrhythmias, about the lack of the
14 accounting for them in the days before the terminal
15 events, is quite logical. And on the basis of that
16 evidence, in combination with their rejection, in
17 any event, that arrhythmias go with SIDS, again, you
18 have to reject SIDS on that ground. But there is
19 another ground. You don't have to rely just on those
20 two. And that is that every doctor that testified,
21 Dr. Rowe, Fowler, Becker, Bain, Hastreiter, Carlton,
22 Mirkin, and deSa agrees that this is a diagnosis
23 which is only appropriate once. All other possible
24 causes of death have been excluded. To use a phrase
25 that I think we have all become rather sick of "the
diagnosis of exclusion."



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Dr. Fowler admitted because digoxin intoxication had not been ruled out that you couldn't say definitively, in this case, that the diagnosis of SIDS was an appropriate one. Dr. Becker, himself, indicated that before coming to a diagnosis of SIDS that he would want to rule out infection and other causes of chronic hypoxia, in his words, such as congenital heart disease.

I go back now to Exhibit 410. Well, that is precisely what the doctor at North York General postulated, this child had sick sinus syndrome due to some congenital heard disease. Hastreiter says, "Yes, it is there." Kauffman says, "Yes, it is there. He has got sick sinus syndrome." Dr. Becker also admitted that he would want to rule out other causes which would be discoverable within the confines of his standard autopsy.

And Dr. Bain, whom you will remember, Dr. Rowe, Rose, and Fowler relied upon very heavily, they also admitted that in the Hines case we simply can't rule out digoxin intoxication or can we rule out sick sinus syndrome.

Dr. Hastreiter confirmed that this is a diagnosis of exclusion and that the same two candidates, SSS and digoxin intoxication couldn't be ruled



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He then gives an interesting summary of his views. And he said the evidence against infant death syndrome is that: 1) the child was suffering from sick sinus syndrome; 2) had a structurally normal heart; 3) experienced a very sudden death; 4) the history of arrhythmias preceding the terminal events; 5) the digoxin was found in his tissues when none had been prescribed. And he also said there is further evidence against the SIDS besides the presence of arrhythmias. And that was the type of arrhythmias, the bradycardia preceding the apnea and the fact that the child was on a monitor, and the fact that the child couldn't be resuscitated.

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He also gives evidence that before he would accept sudden infant death syndrome he would want to rule out any toxicological cause. Well, Dr. deSa agrees with that in his letter to Mr. Lamek, which is, I think, Exhibit 421. He said that in his hospital before they will even call it SIDS they do a toxicology screening.

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Dr. Kauffman's reason for rejecting a sudden infant death syndrome is that the autopsy findings are not specific and that the syndrome does not fit the child's clinical course. He testified



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that this child showed some abnormality in his
conduction system and that he had a previous illness
which can explain death and cannot be ruled out.

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He further testified - and this is very important,

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sir, - that there was objective evidence in this

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child of a conduction block, a 2/1 atrial ventricular

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block, and therefore that is another hard indication

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of sick sinus syndrome which had not been ruled out.

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Now you remember I said to Dr. Hastreiter looking at that rhythm strip said you can throw all of this out the window if this was part of the terminal event, and the problem that I am caught in is that I can't prove it was not a strip taken as part of the terminal events so I have to look for other hard objective evidence to convince you of my theory of congenital heart disease or sick sinus syndrome.

There it is right there, the AV block, and Dr. Rowe gave evidence that he had seen in this chart evidence of heart block as well, both at North York General and in admitting at the Hospital for Sick Children, and he confirmed that that was objective hard evidence of sick sinus syndrome, of conduction problems due to congenital heart disease, and he in particular gave that evidence with respect to Kevin Pacsai.

What he did with respect to Hines was confirm that it was there, but it was in testifying on Pacsai that he said, well, what it means when it is there is that that is objective evidence of conduction problems.

Dr. Mirkin indicated that the presence of the arrhythmias and ventricular tachycardia and



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fibrillation were all uncommon to SIDS and that it being a diagnosis of exclusion you have to reject it on that basis.

Lastly, Dr. deSa agrees that it is a diagnosis of exclusion and he says that in his hospital they run toxicologic tests. They were not done here, nor have other causes been apparently ruled out and he says, and this can only mean one thing:

"There is a poor correlation between the clinical picture and morphology."

Now we didn't have the luxury of having Dr. deSa give evidence so I couldn't ask him what he meant by that, but I suggest that you don't have to be a genius to see what he is saying. The clinical picture means what was the kid showing during life and the morphology means what was seen on autopsy. He says there was a poor correlation between those two, so I reject sudden infant death syndrome.

Lastly we come to a very controversial subject: Can a child die in a hospital on a monitor of SIDS? And I am not going to stand here this morning, Mr. Commissioner, and seriously suggest that can't happen because I am sure that it can and I am sure there are reported instances in the literature



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2 where it has happened. But you have the evidence of
3 Dr. Rose, Dr. Kobayashi and Dr. Kauffman that although
4 it can happen it is very rarely seen in the hospital.
5 And I didn't use the word "very"; they did. Very
6 rarely seen in the hospital setting, especially when
7 the child is on the monitor because the monitor is
8 there as an early detection device.

9 I asked Dr. Rose if she could account
10 for the presence of dig. and she said no, she couldn't,
11 other than the possibility of drug error.

12 I put to you, sir, this general
13 proposition which I will come back to later which I
14 think is a major pillar of our theory in the Hines
15 case. If the case were a skyscraper this would be
16 the footings for the skyscraper.

17 SIDS doesn't account for the presence
18 of digoxin so that in the end you can talk about SIDS
19 and all the wonderful theories as much as you want,
20 but in the end the hospital is stuck with a significant
21 amount of digoxin in this body that cannot be accounted
22 for.

23 We know that Drs. Rowe, Fowler, Rose
24 and Bain all gave evidence that the incidents at home
25 were critical to their view of sudden infant death
syndrome. Dr. Rowe went so far as to say if the mother



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2 hadn't intervened the child would have died.

3 Dr. Fowler went so far as to say if the mother hadn't
4 given resuscitation - well, you heard her evidence,
5 sir. It doesn't appear to me the child would have
6 died, at least it is not an obvious proposition,
7 but that's beside the point.

8 The real point is that Dr. Kauffman
9 indicated that the incident at home as related in
10 the chart was completely consistent with a number of
11 things other than SIDS such as an arrhythmia, and we
12 know this child had arrhythmias, and that is what probably
happened at home.

13 He said that the incident at home was
14 not specific to sudden infant death syndrome either.

15 With respect to Dr. Bain and then I
16 would leave the question of SIDS. He is stuck with
17 his own words when he was talking about a chart review,
"this was not satisfactory", and was "second best".

18 He also told us that the purpose of
19 his study - the whole point in doing the study was to
20 put himself in the shoes of the clinicians as they
21 saw the cases back in 1980 and '81 to tell the
22 hospital whether he would have done anything different,
23 whether he would have come to any different conclusions,
24 and if that was his main purpose I suggest to you that
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I 5 the report itself is really not relevant for your
3 purposes.

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You are only interested in the cause of
death; not whether the doctors should have had a
different diagnosis, not whether they should have been
on their warning, not whether they should have done
anything differently. Those are things you can't
report on. And therefore the Bain report can only be
used, it may be tangentially you may take something
out of it.

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He also readily admitted that he had
not had the opportunity to speak to the parents. He
said taking one's own history is 95% of the diagnosis.

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Having gone that far the next question
becomes what does the dig. data mean?

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Well, Dr. Spielberg and Dr. Bain said
that it meant the child had probably received some
digoxin during life. Those were the hospital experts.
They admit it.

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In the opinion of Dr. Hastreiter what
it means is that he had received one or more
unprescribed doses during life.

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Dr. Kauffman's evidence goes much
further. He says that what the levels mean was that
there was "a substantial dose of digoxin given before



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2 death, and a high probability that it contributed to
3 death and a reasonable probability that it was given
4 intentionally".

5 The levels reported in the child
6 conclusively in his view meant that he had received
7 digoxin during life.

8 Mr. Cimbura said that the levels were
9 inconclusive with respect to fixed heart tissue
10 because they were in the overlap range. They fell
11 into both the therapeutic and the toxic range.

12 He did, however, say that the mere
13 presence of dig. in this child who was not prescribed
14 digoxin is highly significant.

15 He reported on his findings at Exhibit
16 95A, B and C and as reproduced for you in Exhibit 423,
17 the summary prepared by Miss Cronk, and he said that
18 in his estimation the concentration of digoxin in
19 fresh heart tissue would not have been less than 252
20 nanograms per gram which he believed to be a very
21 conservative estimate. I commend you to that evidence.
22 I commend you to look at it.

23 His basis for that estimation was
24 very logical. It took into account the myriad of
25 factors that you have to deal with in giving an opinion
on digoxin, and I believe it was a perfectly reliable



I 7 1 methodology for making that estimate.

2 His conclusion was that the child had
3 unquestionably received dig. during life, and I have
4 already indicated that the hospital's doctors, Bain
5 and Spielberg, accept that. It was the evidence of
6 Dr. Mirkin in this case that again there was a high
7 index of suspicion. Dr. Fay, likely cause of death,
8 digoxin.

9 Dr. deSa indicated that a finding of
10 digoxin requires an explanation and is a significant
11 finding in that digoxin may have contributed to this
12 child's death.

13 That, sir, is what the levels mean,
14 make no mistake about it. Don't be fooled by this
15 debate about reliability of exhumed tissues and
16 preserved tissues and fresh tissues and Substance X
17 and the plethora of other things. That summary is
18 what the experts say the levels mean and that is what
19 I submit you have to look at.

20 Now given that those are what the
21 levels mean, what do the experts say with respect to
22 digoxin intoxication as the cause of death?

23 We know that Drs. Rose, Fowler and
24 Rowe all indicated that subject to the debate amongst
25 the pharmacologists Hines may very well have died from



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2 digoxin intoxication. They accept that. They can't
3 tell us whether he did or he didn't. You have to look
4 at the experts with respect to pharmacology.

5 Dr. Becker indicated that if digoxin
6 was found and if the findings are interpreted to mean
7 digoxin intoxication, subject to the pharmacologic
8 debate he would change his view with respect to the
9 cause of death or the mechanism of death, but he would
10 not change his pathological diagnosis.

11 You had an interesting exchange with
12 him. You said what would happen if a child had
13 experienced a missed sudden infant death syndrome episode
14 during life and therefore chronic hypoxia and there-
15 fore showed presence of your four pathological changes,
16 that was poison by digoxin. Dr. Becker said, well,
17 the cause of death would be digoxin overdose but the
18 terminal diagnosis would still be missed sudden infant
19 death syndrome.

20 Well, the terminal diagnosis, sir,
21 with great respect, should be thrown into the waste
22 basket. We are not interested in terminal diagnosis.
23 The pathologists and the scientists may be extremely
24 interested in it.

25 Mr. and Mrs. Hines aren't. I am not.
I don't think you ought to be either. Let's not play



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2 with words.

3 What we are looking at here is the
4 cause of death. Becker can't take back those words.
5 If he is satisfied subject to pharmacologic debate
6 that the levels mean what everyone says they mean,
7 that he change his view on the cause of death.

8 Dr. Becker also admitted with respect
9 to the cause or mechanism of death and I take this
10 up at the very tail end of my cross-examination after
11 it finally got through my thick skull the distinction
12 this man was making when he talked about pathological
13 diagnosis with respect to the mechanism of death and
14 then I based all my questions on tell me about this,
15 that and the other thing as it relates to the
16 mechanism of death, he admits that pathology alone
17 can't tell you the cause of death but you have to look
18 at all the other factors as well, and that is an
19 important piece of evidence because that goes back
20 to the standards that we were talking about.

21 Dr. Bain agreed with Dr. Rowe - he
22 didn't know what the dig. levels meant but he couldn't
23 say definitively it was SIDS because subject to what
24 those levels meant it might have been digoxin intoxi-
25 cation, and he specifically said that he couldn't rule
dig. toxicity out.



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2 Dr. Hastreiter's conclusion was as
3 follows: that even on clinical grounds alone, forget
4 dig., the possibility of a massive digoxin overdose
5 was a good one. He said there was not sufficient
6 evidence to say with certainty that digoxin caused
7 the baby's death but that there was sufficient
8 evidence to make it a "strong probability".

9 Due to the presence of digoxin when
10 it was not prescribed, Dr. Hastreiter felt that that
11 was probably murder. He could not say with certainty
12 what size the dose was but feels the levels reported
13 in the fixed heart tissue were very high. He also
14 testified that digoxin toxicity was a very high
15 probability.

16 Now Mr. Scott would say, well there
17 you go, Mr. Tobias, the doctor said he can't say
18 with certainty that digoxin caused the baby's death.
19 All he can say is that it is a strong probability,
20 and you, Mr. Commissioner, can't reach a conclusion
21 based on strong probability. And I say with the
22 greatest respect to Mr. Scott that is ridiculous.
23 You will never have in this case if you live to be
24 4,000 years old --

25 THE COMMISSIONER: A horrible thought.

MR. TOBIAS: -- and if you spend every



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2 day of those 4,000 years here listening to the experts
3 and reading the transcripts and taking only breaks,
4 sir, to go to the medical library and read the journals,
5 you will never have the smoking gun. It doesn't exist.

6 THE COMMISSIONER: I think I have got
7 to come to Mr. Scott's defense here somewhere. He
8 didn't quite say I had to be absolutely certain. He
9 said that if I thought, as I understand it, on the
10 balance of probabilities that the child died of
11 digoxin poison I should say so. If I thought the
12 child died from natural causes I should say so, but
13 if I didn't know, if I were somewhere in the middle,
14 merely suspicious, his proposition was that I should
15 say nothing.

16 MR. TOBIAS: I say in reply that if
17 you are in the middle and you want to see which way
18 the scales are being tipped, don't look for certainties.
19 Look for the experts' conclusions with respect to
20 probabilities, and if they make sense adopt them, and
21 you can't get much stronger than a strong probability.

22 The evidence of Dr. Kauffman again I
23 underline was that there was a substantial dose of
24 digoxin and a high probability that it contributed to
25 death. So he goes I suppose even further than
Dr. Hastreiter.



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He also said that there was a reasonable probability that it was intentionally given. And again he repeated his evidence about conduction problems making the child more susceptible to digoxin toxicity.

His evidence was that the combination of suddenness of death, characteristics of the terminal event and the findings of digoxin in post mortem fixed tissues led to the conclusion that digoxin was probably, and again he used the word "probably", responsible for death.

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You know what Mr. Cimbura's conclusion was. He voted for probable murder. He does say, as a caveat that the levels obtained, in and of and by themselves were inconclusive. The fact that it was there, though, is significant.

Dr. Mirkin attributed a high index of suspicion, not only because of the dig, but because of the presence of the bradycardia and apnea and that he felt -- I am sorry, Dr. Fay felt the likely cause was digoxin and he also voted to put it in the probable murder category.

We have dealt, sir, with SIDS and we have dealt with digoxin intoxication. I would like to deal with sick sinus syndrome. It may seem that I am wasting your time, but I promise you, sir, that I will show you later why it is important.. Well, maybe I had better give you a hint of that now.

I say that digoxin or that SIDS, can't account for the presence of digoxin. Becker said to me in my cross-examination, well, how does digoxin intoxication account for the four pathological changes? If he had sick sinus syndrome, but died from digoxin, we would have the four changes there. That is why it is important that we look at that



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2 evidence.

3 Dr. Rowe indicated, number one, no
4 conduction study, can't rule it out, the child may
5 have had it.

6 Number two, signs in his medical
7 record of heart block which is objective evidence
8 of sick sinus.

9 Number three, there was evidence at
10 North York General Hospital and on admission to
11 the Hospital for Sick Children, this child had
12 heart block, had myocardial failure, which was not
13 seen, I grant you at H.S.C., but at North York
14 General and, therefore, there was objective evidence
15 of sick sinus syndrome.

16 Dr. Fowler agreed that if there is
17 no conduction study you can't rule out Triple S,
18 and you also, having periods of bradycardia and
19 tachycardia, together with apnea, this was all
20 consistent with conduction problems, therefore,
21 there was a clinical history of conduction problems.

22 Dr. Rose confirmed that. No conduction
23 study, you can't rule it out, clinical symptoms are
24 there.

25 Dr. Becker, himself, admitted that
another possibility to account for the tachycardia



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2 in this case was a problem with the conduction
3 system.

4 Dr. Bain, again admitted the same
5 evidence. Dr. Costigan gave evidence that he wanted
6 to rule out conduction problems because he suspected
7 them. Dr. Hastreiter agreed with all of those
8 doctors that you can't rule it out. You just don't
9 know the conduction system, our study was not done
10 and here we have got underlying arrhythmias which
11 make a diagnosis of sick sinus syndrome very likely.

12 Dr. Kauffman again finds the two to
13 one atrial ventricular block which Dr. Rowe had
14 testified about. He sees the evidence of underlying
15 illness and he sees the arrhythmias and he says
16 that is consistent in every way with conduction
17 problems. He thinks the child had conduction problems.

18 Evidence has been given before this
19 Commission that bradycardia is a common occurrence
20 in sick sinus syndrome. Dr. Rowe, Dr. Fowler and
21 Dr. Rose all agreed with that. That is part of sick
22 sinus syndrome, bradycardia.

23 Now, if, as the expert evidence
24 suggests, this child was suffering from sick sinus
25 syndrome, the periods of apnea, which were documented
can be accounted for as a result of the episodes of



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bradycardia. Again, the doctors agreed with that, that apnea could be a result from the bradycardia. So in other words he has a conduction problem, the heart slows down and that in and of and by itself causes it to go into apnea.

Now, I say that if the periods of bradycardia which go along with the Triple S can count and are very common in accounting, then as a result of the apnea you would have a deprivation of oxygen. That is what chronic hypoxia is and the changes that Dr. Becker had seen would be there, but then the child was given a digoxin overdose and I asked Dr. Hastreiter, with sick sinus syndrome, in your opinion, would you have expected him to die from that and he said, no.

Sir, if sudden infant death syndrome is not the answer, because it is not consistent with the dig. that was found and if dig. intoxication is the answer, because the weight of the evidence points in that direction, and is completely compatible with the changes that Dr. Becker saw --

THE COMMISSIONER: Whose evidence was it that he would not be expected to die from sick sinus syndrome?

MR. TOBIAS: Dr. Hastrieter. If you are



J-5

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2 satisfied on that basis then you have only one more
3 thing to decide: did he die from digoxin intoxication
4 by medication error. I would like to deal with
5 that.

6 I think we have to start by looking
7 at what could have happened. There are five possibil-
8 ities: either that the digoxin was given by error
9 during resuscitation; that it was given by mistake
10 by someone thinking it was ampicillin; that it was
11 given by mistake by someone thinking it was gentamicin;
12 that it was given by mistake by someone thinking it
13 was some other drug; or that it wasn't given by mistake
14 but it was given to the wrong baby and in that last
15 scenario you have to look at two possibilities: it
16 could have been given in the correct dose to the
17 wrong baby or there could have been two mistakes
18 to the wrong baby and in a greater amount than should
19 have been given. I would like to canvass briefly
20 those possibilities.

21 During resuscitation you would have
22 to have the digoxin on the crash cart and both
23 Drs. Rose and Dr. Costigan indicated that it was
24 not kept on the crash cart.

25 Dr. Kobayashi, Dr. Hastreiter and
Dr. Kauffman testified that during the Hines



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2 resuscitation effort, and based on their notes or
3 their observations of the arrest note that Dr.
4 Costigan made, and which appears, sir, in the medical
5 record at page 69, those observations lead them
6 to the conclusion that during that resuscitation
7 effort the circulatory system was profoundly
8 impaired and in Dr. Kobayashi's opinion, hardly
9 working at all.

10 Dr. Spielberg taught us, at least I
11 think it was Dr. Spielberg - someone taught us at
12 some point throughout this proceeding -- that the
13 circulatory system is the delivery system, transport
14 system.

15 Dr. Hastreiter and Dr. Kauffman had
16 indicated the levels seen in Hines could not be accounted
17 for by way of a mistaken administration of digoxin
18 given during resuscitation, because given the
19 impairment of the circulatory system there would
20 simply not be sufficient distribution to the tissues
21 to account for the levels seen.

22 Could it have been given for ampicillin?
23 Well, Drs. Hastreiter, Kauffman and Spielberg have
24 all testified that this is very unlikely, because
25 the obvious problem is the difference in the
containers that the drugs



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2 come in and, even more obvious than that, ampicillin
3 is a powder and you have to dilute it in solution--
4 not dilute it, I am sorry, you have to put it in
5 solvent in order to make it liquid in order to give
6 it. So that is not a very likely scenario at all.
7 As well, if an error of that sort occurred the
8 evidence has been that it was probably far more
9 likely to have occurred on March 7th than on March
10 6th, because March 6th we had the child in a room
11 by himself, in isolation. Now, could it have
12 happened on the 7th? Well, it may have, but I say
13 to you this: the evidence clearly is that digoxin
14 as a matter of routine, is given at 9:00 a.m., at
15 9 and 9:00 p.m.

16 If you look at the chart, page 83,
17 and you look at the medication record, there were
18 seven drugs, or I shouldn't say seven drugs, there
19 were two drugs scheduled to be administered at
20 seven times during March 7th, 1981. The only time
21 a drug was to be given at 9:00 a.m. or p.m. was
22 the 9:00 p.m. administration of gentamicin. Now,
23 it is possible that that could have been when the
24 error happened but Dr. Hastreiter indicated that
25 this was extremely unlikely, because digoxin and
gentamicin come in strikingly different vials, and



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2 you have seen, as an exhibit -- I can't remember
3 whether it was 224 or 225 -- but you have seen an
4 exhibit wherein vials of lanoxin and vials of
5 gentamicin are before you. I think if you look at
6 them you will be struck with the striking difference
7 in those vials.

8 As well, there is one last problem
9 with the digoxin for ampicillin and the digoxin
10 for gentamicin and that is this: you have to decide
11 on the basis of the evidence before you. It is not
12 your fault if evidence exists and it wasn't put
13 forward. We all had an opportunity to call witnesses.
14 Now, there isn't a shread of evidence before you,
15 not one, that the other four children, who were in
16 room 431 on March 7th, 1981, were on digoxin.

17 Before Mr. Scott, in his absence,
18 starts getting hot under his collar about that,
19 yes, the inference is there. There is no question
20 about it, because this is a cardiac ward and a lot
21 of the children were on digoxin. It is not a hard
22 matter to prove, not a hard matter to prove at all.
23 I have to believe that in the absence of calling that
24 evidence it is just as fair to draw the inference
25 that those children weren't on digoxin, and inferences
aside, you still have to decide on the basis of the



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2 evidence in the record, there is no evidence that
3 any of them were on dig.

4 I rely on the opinion of Dr. Hastreiter
5 regarding the possibility of confusing digoxin for
6 gentamicin. Dr. Spielberg has testified, with
7 respect to digoxin being mistaken with another drug,
8 that this would be less likely to have occurred on
9 March 6th, because the child was in isolation. There
10 was no evidence, as I have said, to support the
11 proposition that the other children were on digoxin
12 and both Dr. Hastreiter and Dr. Kauffman had been
13 giving evidence that the levels seen in the fixed
14 tissue of Jordan Hines, were not consistent with
15 one accidental administration of a maintenance
16 dose and in Dr. Kauffman's case he went further. He
17 at first indicated to Miss Cronk that it might be
18 consistent with a loading dose given by accident
19 and then when I cross-examined him he said, no, it
20 would not be accounted for by a single administration
21 of a loading dose.

22 Hastreiter said, with respect to
23 a loading dose, that you might get these levels from
24 an accidental administration, one loading dose
25 but that in and of itself is unlikely, because
loading doses are not given at one time. They are



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2 broken into several administrations, so you would
3 have to have multiple error.

4 Again, for this reason, Kauffman,
5 Hastreiter and Mirkin all testified that the drug
6 error theory, in this case, forget generally, but
7 in this case, was extremely unlikely.

8 Lastly, how about giving digoxin
9 knowing that it is digoxin but to the wrong baby?
10 Again, not a very good chance on Ward 6. More
11 importantly, however that Dr. Kauffman testified
12 that to get the level seen in Hines one would need
13 an error whereby the wrong dose was given to the
14 wrong baby or there were -- in other words, it is
15 got to be not just a correct dose to the wrong baby,
16 but a dose too high to the wrong baby or there were
17 several multiple administrations of the correct
18 dose to the wrong baby. Both cases come to the
19 same thing, multiple error and therefore unlikely.

20 It must also be remembered, sir, that
21 you have to look at this death against the back
22 drop of the others and we know there were three
23 other babies not on digoxin.

24 It is extremely unlikely that the
25 drug error can account for digoxin in all of these
babies, especially when again there has been no



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evidence called by the Hospital to indicate that drug errors were occurring on other wards and in the presence of other nursing teams and at other times on a random basis.

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I am in your hands, sir. I could probably finish up in about ten minutes.

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THE COMMISSIONER: Well, I think if you would. I think that is advisable.

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MR. TOBIAS: This death has to be reviewed as a series and while hospital experts testified as to the likelihood, as the cause of death being sudden infant death syndrome, they had to acknowledge that it was at the very best a controversial diagnosis and one which is subject to much ongoing research and that which the state of knowledge is rudimentary. None of the hospital experts could definitively call it SIDS and aside from the pathological diagnosis of sudden infant death syndrome you have the problems with the clinical history and even the hospital experts had to recognize that.

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On the other hand, each of the experts, with the exception of Dr. Nadas, from outside of the hospital give evidence with respect to sudden infant death syndrome as to the cause of death and rejected it as a diagnosis of exclusion which wouldn't account for the history of admittance.

In particular, we must look at the argument of Drs. deSa, Kauffman and Hastreiter. Dr. deSa, as I have indicated, rejects out of hand that the changes seen at autopsy are specific to SIDS. His view is shared by Hastreiter and Kauffman.

They add the clinical element to the argument saying that this child had serious underlying illness. He was suffering from conduction problems.

On the basis of the controversial nature of the diagnosis and the conflicting evidence and the admission made by the experts at the Hospital for Sick Children, and the complete lack of support by the diagnosis by any doctor outside the hospital, I submit to you that you cannot on a balance of probabilities conclude that this child died of sudden infant death syndrome.

As Mr. Lamek so well stated it the other day, it unfortunately pits doctors in the hospital against the doctors outside of the hospital.



None of us, with all the goodwill in the world, can fail to recognize that the hospital staff can't come here and give entirely, completely, one hundred percent objective evidence divorced entirely from their concern for that institution.

Now, there are four explanations for death of Hines that are still in the running. Triple S, sudden infant death syndrome, digoxin intoxication or some unknown cause.

We can't rule out the sick sinus syndrome because of the absence of a test on the conduction system, but it is clear that sick sinus syndrome doesn't account for the presence of digoxin in the baby.

With respect to sudden infant death syndrome. It is a diagnosis of exclusion and neither digoxin toxicity, in the opinion of Dr. deSa, nor conduction problems, in the opinion of all the hospital experts, and Drs. Hastreiter and Kauffman, have been excluded. More importantly than any of those factors is the fact that if sudden infant death syndrome could account for the death, which is not the case, it doesn't account for the presence of digoxin.

As well, Dr. Hastreiter says "Don't look



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2 just at the arrhythmias seen in the terminal events,
3 look at the arrhythmias preceding the terminal events."

4 Now, I won't deal with respect to the
5 unknown cause because there is nothing in support of
6 that. It was just a thought put forward by
7 Dr. Fowler.

8 With respect to digoxin intoxication,
9 the evidence is clear. As stated by Dr. Cimbura and
10 Dr. Spielberg, as well as the other experts from the
11 hospital, the finding of dig. conclusively establishes
12 that digoxin had been given during life. Dr. Kauffman
13 and Dr. Hastreiter say that it could not have been
14 given during resuscitation because of the lack of
15 distribution we couldn't have got these readings.

16 I also say that the levels could not
17 be accounted for by one accidental administration of
18 a maintenance dose nor of a loading dose. And in
19 Hastreiter's case, "Yes, possibly a loading dose".
20 But that is an extremely unlikely error.

21 As well, Dr. Becker states and
22 challenges me, as it were, saying that if it was
23 digoxin intoxication, why the changes? Well, as I have
24 said, the changes can be accounted for due to chronic
25 hypoxia caused by sick sinus syndrome. And it is
clear on the record, and supported by all the cardiology



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experts, that this child did have conduction problems and that that results in the bradycardia which in turn brings on apnea, which in turn brings on chronic hypoxia.

The reference, sir, to Dr. Hastreiter specifically testifying that he would not have expected Hines to succumb to triple S is at Volume 81, page 76-78, on line 23 to page 7679, line 10.

Now, I submit to you, sir, given the high probability that the cause of death in this case was due to digoxin intoxication and due to the unlikelihood, on a balance of probabilities, of it being given by error, the only rational conclusion that one can draw is that this child died from an intentional administration of a dose in sufficient quantities to cause death.

To come to another conclusion, I think, is to place too much reliance on Dr. Becker's diagnosis because Dr. Becker's diagnosis in the end is based upon findings that are not universally accepted. And, as well with respect to arrhythmias is based upon an academic theory. When you compare that to Dr. deSa's evidence you have to prefer Dr. deSa's evidence.

Finally, I would say this - and I can put it no higher than this. The simplest way to look



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2 at this case is to take the opinion, which is supported
3 by Dr. Becker and Dr. Bain on the one hand, and compare
4 it to the contrary view which is supported by Dr. deSa,
5 Hastreiter and Kauffman.

6 The view of Dr. Becker and Dr. Bain is
7 that the child showed changes at autopsy which were
8 consistent in every way with SIDS. And he shows the
9 clinical history which is consistent with SIDS
10 episodes and was, therefore, at higher risk of dying
11 from that syndrome.

12 And in the final analysis, given all
13 that I have said, the argument must fail because it
14 simply doesn't account for the presence of digoxin,
15 nor the history of the type of arrhythmias. On the
16 other hand, the views of deSa, Kauffman and Hastreiter
17 that there is compelling evidence - sorry - or that
18 there is no compelling evidence of sudden infant
19 death syndrome. However, the presence of digoxin
20 in the tissues accounts for the death by way of an
21 unprescribed dose, intentionally given.

22 In this scenario we can account for
23 Dr. Becker's findings which are, in every way,
24 consistent with the sick sinus syndrome which can in
25 turn, as I said before, cause the chronic hypoxia
which would show up on the autopsy.



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In short, sudden infant death syndrome is incompatible with the clinical history and the digoxin findings. Whereas digoxin toxicity in combination with the triple S argument is entirely compatible with the clinical history and the post mortem findings in the tissue and the findings at autopsy.

So, for all of those reasons, I would submit to you that the vast weight of evidence in this case can lead to no other conclusion, on a balance of probabilities, than that death in the case of Jordan Hines was caused by an unprescribed dose of digoxin given during life intentionally, and in sufficient quantities that it produced death.

Thank you, sir.

THE COMMISSIONER: Thank you, Mr. Tobias.

Well, I think we will rise now to 2:30. I don't see either --

MR. LABOW: Mr. Commissioner, can I indicate to you that Mr. Shanahan will go next and Mr. Olah expects to follow him and be the rest of the day.

THE COMMISSIONER: Yes. All right. Thank you. 2:30, I take it. Will that cause us some



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problems?

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MR. LABOW: No. At the very worst

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Mr. Shanahan will be a little early.

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THE COMMISSIONER: Yes. I didn't mean

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that so much, but Mr. Olah is threatening to take the
rest of the day.

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MR. LABOW: Yes, he should still

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finish.

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THE COMMISSIONER: Yes. All right.

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--- Luncheon recess

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---Upon resuming at 2:30 p.m.

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THE COMMISSIONER: Yes, Mr. Shanahan.

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MR. SHANAHAN: Yes, Mr. Commissioner.

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Mr. Olah was here earlier, sir, and he spoke with me and asked that he be permitted to go last. He says he is going to show up around three o'clock and he will be ready then. I will filibuster until then if I can.

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THE COMMISSIONER: All right.

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MR. SHANAHAN: Sir, I wasn't here when --

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THE COMMISSIONER: He is taking over from you.

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ARGUMENT BY MR. SHANAHAN:

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I wasn't here, sir, when Mr. Tobias made his opening so I don't know whether this comment holds true for him, but I note that the lawyers for the parents so far, sir, as I have heard it, have not expressed to you their appreciation for the manner in which this Commission has been handled. And I think, sir, at the outset that specifically my two clients have asked me to convey to you, not only, sir, and I might say that Mr. Lombardo has personally conveyed to the Attorney General, as is his way, in fact is grateful for the whole Commission and the ambit and the scope of it.

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He has as well instructed me and as has

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Mrs. Dawson, to convey to you, sir, the fact that you have granted them standing. You made that standing, sir, something meaningful by the way in which you assisted Counsel. That, sir, is something that they are eternally grateful for. The Commission has been useful for them, sir. It has let them know a great deal about what happened during that time period.

I might say, sir, more than them I have been here and you have tolerated my many goings and comings here. But when I have been here, sir, I might say to you that I have found that you have been fair and even handed in all your handling of this matter.

I might say after the Court of Appeal ruling even then, sir, when it perplexed us for the days following, you have taken a generous and a liberal interpretation so the parents would still be able to see and hear what went on here.

All is well that ends well, sir. We differed, you and I, with respect to the standing of Phase II, but I hope, sir, in a few months' time I will still be here, still addressing you and making submissions about that.

At the outset, sir, I think many Counsel have addressed you with respect to evidentiary



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issues. After 11 months, of going through circumstances surrounding the various children, that they have I suppose in a spirit of humility, they still, though, sir, have asked you to direct your mind as to the approach that you will take, the various types of evidences, the totality of the evidence, the inferences that you can draw and some of them have spoken to you about the burdens that you must bear in mind.

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I, sir, too - I know this ground has been covered and I will try not to plough the same field, but I, sir, wish to put to you my considerations with respect to some of these evidentiary matters.

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One, sir, that arises at the outset is the use to be made of the patterns themselves. I think Mr. Lamek had a view on that, and I think there were other opinions expressed by other individuals with respect to that.

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I, sir, say to you that really the most fundamental and undisputed pattern here is the stunning rise in the deaths on the ward during that time.

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The rest, sir, are features of that pattern. The ward, the night, the age of the children, the team, they are features, sir, but the most



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fundamental aspect (it is really self-defining) it tells us this epidemic is an epidemic and this epidemic began in June and ended in March.

It tells us, sir - it really cries out for answers - the scope of it, the magnitude of the number of deaths.

What may, sir, have been intuition at the time as nurses and doctors to some extent commented and realized the rising number of deaths, it has, sir, now as we look back, it has quite clearly, sir, become an undisputed fact that there was a rise in deaths. The Atlanta Report confirmed it and Dr. Gilmour-Bryson confirmed it.

Dr. Rowe indicated much the same that there were many, many patients died and that they did not die in that rate as he experienced on the ward either in surgery or in ICU.

The features of the pattern that come from that, sir, are features that we have seen and, sir, I submit to you that in fact they are useful and will be extremely useful in marginal cases to decide on a level of suspicion that you attach to the cause of death.

And that, sir, really dovetails with a child who died in that pattern exemplifying all



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the features of that pattern, and died, sir, with a toxicological certainty that the cause of death was digoxin and the effect that child's death should have on the time period, and that is Justin Cook's death.

Justin Cook, sir, with respect, there is no doubt whatsoever about the digoxin that was found by the means of Dr. Cimbura's methodology that we are dealing with pure digoxin, sir - no question that Justin Cook, with respect, was murdered, and if you come to that finding, sir, it casts a shadow and a pall over all of the previous 36 deaths.

But, sir, with respect to Cook, I respectfully suggest to you there are other attendant circumstances that happened in the month of March, with respect, to even give Cook a greater significance. Mr. Labow went through some of this.

Nine died in nine working days, sir. A total of ten died as I recollect in the whole month. Dealing with any kind of numbers that were seen before were ten to die in a month long period, sir, is absolutely outrageous.

There were, sir, two dying with normal hearts, anatomically normal hearts. There



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were, sir, two who died who were subsequently found to have digoxin and digoxin was not even prescribed for them.

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One of them I understand, sir, was the fact that digoxin was even contraindicated. That would be Cook, sir.

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Cook dies, sir, after a general hue and cry over the issue of digoxin. He dies, sir, in spite of the fact there has been increased security with respect to digoxin. He dies in spite of the fact that Pacsai has already started - the issues around Pacsai's death already starting to raise their head.

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He dies, sir, in spite of all the above he dies, sir, as I say numerically nine in nine days, two with normal hearts, he with digoxin not prescribed, he with digoxin when it is contraindicated.

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When you look at Cook, sir, not only the certainty we have with respect to the toxicological information, when you look at Cook, sir, in relation to all the other attendant circumstances, you really come to the conclusion, sir, where there was a situation here where a person or persons had really now become so bad minded enough or perverse enough that they were ready to persevere in spite of all



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these circumstances and to see through whatever scheme or plan they had with respect to deliberately giving this child an overdose of digoxin.

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As well, sir, with respect, Cook gives a new meaning to the pattern that we discussed. Whereas before I had said to you, sir, the most fundamental pattern is the magnitude of the rise in deaths.

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Then, sir, when Cook as we see enjoys the features or shares the features of the ward association, death at night, death with a certain team, all the other factors we have seen, Cook then takes those factors, sir, and with respect with a certain loss of innocence. Now those features, sir, which may be neutral if you like, if you like - certainly if there were error and things of that nature they would be random, the pattern itself may be suspicious, but Cook, sir, galvanized that.

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Cook, sir, clearly then shows that pattern does have meaning and the meaning, sir, is nothing other than sinister.

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As well as that, sir, there is a certain loss of innocence insofar as it leads you to the conclusion that in that Hospital, committed to the care of children and that staff, committed to the



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care of children, that someone there or some person or persons there that would normally be dedicated to the care of these children, would be the custodians of these children, someone there now as difficult as that result may be to accept, clearly someone has formed that purpose, has the ability to carry it out and as I say, had this single-mindedness to see it through.

And that, sir, when you accept that proposition in March, after ten deaths in a month, and all the other circumstances, when you accept it after nine months, when you accept it after thirty-six deaths and you realize that Cook shared the pattern, that, sir, with respect casts a shadow or a pall back over the other thirty-six deaths.

And, sir, it in itself would not be definitive of the issue, but in those deaths where toxicology may be neutral where other aspects may not be as strong as you like, Cook in the surrounding circumstances and what his death means to the Hospital staff and what-have-you, with respect, sir, Cook's death and what Cook's death reveals can be used by you with respect to you gaining an index of suspicion regarding these deaths.

Cook, sir, provides you I would



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submit with a natural perspective for a natural starting off point. He doesn't die as the first death which you might, sir, look forward to deaths, or in the middle where you would look behind you. Cook is the last and Cook is the most certain. Cook has the vantage point with respect through which you look back on that time frame. It has gone from us. You look back on it in hindsight in any event and I suggest to you Cook is in the unique position of being last but also the most certain.

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If you can look through that, sir, and draw the conclusion, sir, that I suggest you draw in fact Cook goes a great way to assist you in those children who may occupy the middle ground.

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That flows again, sir, into a discussion that many have had with you with respect to standard of proof you are to apply. I submit to you, sir, quite clearly by definition you are not in a civil trial and you are not bound by even establishing matters on a balance of probabilities. You are not in a criminal trial; we have been told that. We have been warned about that. Certainly, sir, you do not have to approach the burden of proof beyond a reasonable doubt.

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There is, sir, because this Commission,



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because of the formalities of trial procedure, civil

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or criminal have been put aside, with respect, sir,

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because of that there is no prescribed formal burden

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that you must meet.

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There is no burden, there is no onus on any party.

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There is through Commission Counsel a complete airing
of the facts put before you, sir, and you, sir, are
to judge them.

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We, sir, act for various interests.

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We are at times adverse, we advance our client's
interests, we question with a view to getting to the
bottom of the matter, but you, sir, have no interest.

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Beyond that you, sir, have the burden, if you like,

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of a duty, the obligation to synthesize all of that

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evidence, to analyze that evidence and to come to an

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honest judgment. I think that, sir, is really the

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only onus you have is to use your common sense, to

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approach it, sir, directly and honestly and to come

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to an answer. As difficult, sir, as all the evidence

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may be to analyze, my clients wish you to grasp the

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nettle, if you like, to address the issues and not to

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adopt any instructions, sir, that might suggest to you

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where things are difficult or gray or hazy and, in

fact, you leave them there and you don't approach the
issue.

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Sir, in terms of weighing the evidence,

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I would ask you, as I am sure you will, to be mindful

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of a number of aspects. One, sir, is that many experts

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have come before you, but I would suggest to you, sir,

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BB 2 that one group of experts also enjoy a dual function and, as a result of enjoying that dual function, sir, I think the weight you must give to their evidence must be very carefully chosen.

The Hospital has brought forward people here who really enjoy a unique position. Their evidence, in some respects, sir, must be given a unique weight, because they are the very people who saw these children, and I am not dealing now with old medical records. They saw them, dealt with them and they assisted these children and they came to opinions on these children. That, sir, maybe gives them an especially useful vantage point.

But in another aspect, sir, I think you have to be mindful of the undisputed fact that they are players in this drama, sir. They are part of the *dramatis personae* here of this whole epidemic period. It would be inhuman, sir, if they didn't arrive at conclusions here, and from a human point of view not wish to be moved back. It would be inhuman sir if there wasn't a natural entrenching of their positions. It would be inhuman, sir, that their actions and that of the hospital they worked for coming under scrutiny, as it has here, that there wouldn't be a certain, if you like, defensiveness about their position. They do



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BB 3 come to us as experts. I didn't see, sir, or view any overt signs that their professional judgment was clouded by their position. I think, sir, as well, you could note to a man, Dr. Rowe, for instance, I would submit to you, kindly to him, that there were certainly, over the long scope of the evidence, I felt there were times that he and others were entrenched in their position and I attributed that, sir, and I submit that to you, that you should as well be mindful that they were actors in this drama and that certainly has to go to the weight of their evidence.

As well as that, sir, at times experts, if you like, have been played off against each other. That caused me a problem when I was first addressing this, especially between cardiologists and pharmacologists, Bear in mind, sir, at times when Dr. Hastreiter would say one thing why Dr. Kauffman wouldn't be so certain. I am mindful then, as I came to the end of it, and I think I have the answer for you to some extent, and that is obviously Dr. Kauffman at times was looking at and came into full bloom when he had toxicology data. That was his forum. He wasn't per se a cardiologist. He wasn't getting into that systematic and clinical assessment. He was



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BB 4 2 looking for toxicology. When he had it he could
3 interpret it and he could tell us routes and times and he
4 could tell us the amounts and he could tell us the
5 effects. Therefore, sir, when he came to other
6 children where he was less certain I don't think, sir,
7 it was a suggestion overall that he couldn't say about
8 digoxin intoxication. He was simply saying that in
his area of expertise he lacked the data.

9 Conversely, in terms of Dr. Hastreiter,
10 when he could quite honestly say that the symptoms,
11 that the clinical assessments were reasonably neutral.
12 Even when we come to Kauffman or Mirkin -- I am not
13 calling them doctors here for no lack of respect, but
14 Kauffman or Mirkin would come in here and could be
15 more certain because of the toxicology which they had
which was their area of expertise.

16 You, sir, will synthesize all of that
17 and that is why I say to you, sir, here in dealing with
18 the experts here that you will, sir, have to, you can
19 and have to, you do it in a civil trial and you do it
20 in any trial, sir, you can accept part or all and you
can reject part or all of any of their evidence, sir.

21 Another aspect, sir, is that I think
22 it was urged upon you, I don't think in so many words,
23 but I think the net effect was that if you needed a
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degree of assurance, sir, that really approached it, if you like, I thought with scientific certainty. I am suggesting to you that would not be accepted by you. It would immobilize you, sir, and it would neutralize you completely. I would submit to you, sir, that that approach was the chief roadblock discerning the underlying causes of this epidemic period at the time. It was this approach, if you like, that led really to the true causes of these deaths and the true cause of these clusterings and patterns really being missed.

The queries of the nurses, sir, were soothed by medical explanations. We had put forward the fact that it was understaffing and there was clustering, a scientific phenomenon seen as clustering. The deaths were treated in isolation. There was never an overview, never an individual or individuals standing back and looking at that broader pattern, that broader set of events.

If, sir, I would submit to you the whole broader picture were then resorted to, the use of the patterns, if you like, sir, the features of these deaths. These theories that were then offering cold comfort to people, such as errors, and as I say, such as understaffing and what have you, with respect,



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BB 6

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sir, these explanations would have been seen to be
3 wanting and to be lacking.

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There were warning signs along the way,
sir. There was the Estrella reading which the
scientists dismissed and thought was an artifact.
There was around the same time a surgeon's letter;
I think there is an exhibit here, the exhibit was 64
on December 15, 1980 Dr. Trusler, I think it was, wrote
to Dr. Rowe about 15 or 20 deaths and what have you
and indicated that surgery was successful, that they
were dying on the ward. It was, sir, a problem with
the nurses repeated concerns, returning to the doctors
looking for explanations and it was the problem of
Baby Taylor, yet again, sir, there was the resorting
to these explanations, dealing with the children
individually and then giving scientific explanations
which seemed to offer comfort to the ordinary
individual.

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I am submitting to you, sir, that you
don't deal with them in isolation, that you see the
broader scope and pattern and I am suggesting to you,
sir, that you don't have to look for scientific
certainty here, you won't find it, sir. It will
neutralize you.

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There may have been blinkers on then,



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sir, unwittingly, because they were preoccupied with one death, as it arose and there may have unwittingly have been a certain myopia that set in. If you adopt, sir, those guidelines you will consciously then be putting yourself in a position where you are linking yourself, aligning yourself to a mass of evidence that is relevant, it is corroborative, supportive, sir, of the goings on there being other than natural deaths and, in fact, having sinister causes.

Sir, with respect then to the specific babies that I act for I would like to turn you, sir, to the child, Lombardo.

You have ample charts in front of you, sir, and through Miss Cronk and through the hospital and through Mr. Percival, sir, you have more than enough telling you the times and dates, but if I can just sum up for you here, sir, and I am just going to sum up those features which I think, sir, will lead you to the conclusion that I wish to draw about that death.

The child, sir, died foursquare within the features of the patterns that we have looked at. The child died at 4:20 in the morning, sir. It died on 4A. It died, sir, where so many of these deaths were repeating themselves in Room 418. It died on



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December 23rd, 10 days old. The child had been operated on, sir. The operation was successful. There is no suggestion, sir, that this child was subject to heroic surgery, palliative surgery at all. The child was assessed and had a repairable feature. It was operated on and it survived that, sir.

In the medical records there is a report, sir, of that operation. That report, sir, has a life of its own and is written, signed on the day that this operation was done and reveals a state of mind of that person at that particular point in time and in the medical records, sir, at page 75 is a discussion of the operative procedure.

Under the heading, sir, of Operative Procedure, about the fourth line in:

"The size of the main P.A. was 4 mms in diameter. The size was too small to work with a prosthetic graft as we had expected to do. So we decided to do a window between the ascending aorta and the P.A. We did it in the usual way, and the lumen of this window was 2.5 mms. We noticed an improvement in the systemic pO2 rising from 27 to 47.



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" Then the pericardium was closed,
and after careful hemostasis and
inserting chest tubes in the
anterior mediastinum and right
chest, the patient was closed in
the usual manner.

She was sent to the I.C.U. in
good hemodynamic status."

To summarize the child and her
defects and the operation, an arterial window between
the ascending aorta and the main P.A. - pulmonary
artery - gives the diameter and said that she under-
went this operation without problems.

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JR/hr

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She did, sir. I would suggest to you, sir, that she was on an improving course. The Stephanie Lombardo, sir, wasn't just, she wasn't lingering, she was improving, sir. She moves along, sir, in the normal anticipated time and is transferred from I.C.U. to the ward. Transferred, sir, on December 22nd. And, sir, she had transferred on the basis of another note that is in that medical record, sir. And if I turn you to that very briefly... a transfer note, I think, done by Dr. Jedeikin and appearing, sir, at page 38.

That transfer note, sir, sums up her position. Sir, in there are the features that clearly show the improvement that this child had made since the operation have occurred.

Indication that the child is in - line 4, in the heavy dark writing around the middle of the page, sir - is that she is stable and on 40 per cent oxygen, p.O. is in the 40's, U.O. which is the urinary output, is good. Her colour is pink. She is dusky when she cries. She is not in distress.

Jumping down, sir. The child's colouring is good and her p.O. #2 is up - that is an arrow pointing upwards. So, one must assume reasonable shunt of function. Nutrition is there. She is a



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candidate, it says in the last line, for transfer to the ward.

Sir, that the evidence is that the operation is successful. The evidence is with respect to her P.O. 2 ratings and the fact that the child has good air entry and that the shunt, itself, is opened.

She is feeding well, sir. She is not on oxygen on the day that she died, sir. She is pink in one ear and that would suggest, sir, that there is good oxygenation in the blood. She is not on I.V., sir. She is not on any other medication, sir, other than heparin. I would suggest to you, sir, that is indicative of the fact that there is no general disease. There is no suggestion of infection in the lungs, or whatever we have seen in many of the other children.

The child, sir, has done well. She has been taken off intravenous. She is feeding from her bottle so that she can now take formula, sir. Her colour, her oxygen, all are good. She then, sir, comes to the ward. Her change is sudden. It is sharp. It is unexpected and it is ward associated, sir.

That, really, sir, again, is so



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2 damaging. It is as if, sir, when Lombardo arrived
3 on the ward she were almost marked for death because
4 within hours, sir, - really the very first shift
5 that is going to see her through. She arrives,
6 I understand, around mid day and on the first full
7 shift, from 7:00 o'clock onwards, it is as if that
8 child had been picked. That child, inspite of how
9 well she had done, falls off the end of the table .

10 Her trauma symptoms, sir, with respect
11 display classic symptoms of all the children that
12 are suspicious gets here and specifically, sir, of
13 digoxin intoxication.

14 She is restless, shallow breathing,
15 her apex becomes irregular, she is bradycardic, she
16 is cyanotic, she vomits, she has ventricular fibrillation.
17 She goes into cardiac arrest.

18 Ward too busy, sir, the suggestion that
19 there might be understaffing? Not so with Stephanie
20 Lombardo, sir. As you have heard, it was Christmas
21 time. Most of the children were sent home. There
22 was a reduced ward population. The nursing load,
23 sir, there has never been a breathe or a hint or
24 a suggestion, in fact, they were understaffed.

25 With respect to her surgery, itself.
26 There is no suggestion that it was in any way



CC-4

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2 heroic. Apparently, her surgery, she was a fit
3 candidate and she survived it well.

4 With respect to the final events,
5 sir. Lombardo didn't go quietly into the night.
6 In spite, sir, of heroic efforts of resuscitation
7 again, she displayed another feature that all of the
8 other children have all displayed, that is the
9 downward decline, sir, that was just irreversible.
10 And in spite of all the resuscitation attempts, a
11 child that has done so well, that she graduated from
12 I.C.U. to the ward, was doing so well during the
13 day, removed her I.V. line, feeding well and stable;
14 that child, sir, cannot be resuscitated despite
15 all the heroic measures. Her toxicology, sir, then
16 provides us with the second piece of evidence with
17 respect to her cause of death. I want you to bear
18 in mind, if you would, sir, that as I have stated
19 in terms of this toxicology that she is not on
20 digoxin. In fact, it was indicated that digoxin ^w
21 would be contraindicative for her. As I understood
22 that, sir, her heart condition was such that she
23 would be uniquely sensitive - distinctly sensitive
24 to digoxin and its effects, be it in a normal therapeutic
25 dose, be it in any toxic overdose whatsoever.

The reading, sir, I think you have



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2 had put before you there, in Exhibit 95, but I
3 prefer, if you like, the exhibit that Miss Cronk
4 put in just recently, Exhibit 423, in which she
5 set out in there for you the reading with respect
6 to Stephanie Lombardo.

7 Lombardo, sir, not being on digoxin,
8 was never tested for digoxin in life. Post mortem,
9 sir, we have only exhumed tissue. The number, sir,
10 as you can see, from that exhibit -- if you have it
11 located -- Lombardo is on page 14, sir. And, you
12 have there ranging seven samples, sir, of chest
13 fluid, heart tissue, lung tissue, muscle, and small
14 bowel. One, sir, was a fluid. The others were
15 fluid tissues. The heart tissues, sir, from the
16 septum to the ventricle were analysed, sir, by a
17 methodology and a technique which, with the greatest
18 of respect, has put beyond all doubt whether in
19 fact we are dealing with pure digoxin or any other
20 substance.

21 Those, sir, the chest fluid, the
22 heart tissue were all analysed, sir, by IRA, HPLC and
23 mass spectrometry after IRA again.

24 I submit to you, sir, the method of
25 establishing qualitatively here the presence of
digoxin, it is pure digoxin, and I think the evidence



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2 shows that Spielberg, Mirkin, Kauffman, all agree
3 that Cimbura's tests were done in that fashion that,
4 in fact, it revealed pure digoxin . . . As well as that,
5 sir, the recent conference at the Hospital, I
6 think, clearly laid to rest any concern on their
7 part that the methodology, sir, revealed pure digoxin
8 and it was really beyond question.

9 What, sir, then did that lead Dr.
10 Hastreiter to say about the significance of Stephanie
11 Lombardo's condition? If I might, I would like to
12 read that to you, sir. Dr. Hastreiter, sir, was
13 speaking about these matters in Volume 76, at page
14 6787, and continuing, as to what he interpreted the
15 readings to be for Stephanie Lombardo.

16 First of all, he said, sir, that if
17 the chest fluids were blood he thought it would
18 certainly indicate digoxin poisoning.

19 Mr. Lamek put that directly to him
20 and he said, "right". He said - the question then
21 put to him was:

22 "You then referred to the recorded
23 tissue concentrations which clearly
24 was also very high and which at that
25 time had they been measured in fresh
tissue would be strongly suggestive
of poisoning.



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On the other hand, you recognized in your evidence that dehydration and dessication of the tissues may have served to elevate that digoxin concentrations, but you were still inclined to regard the digoxin levels in the exhumed tissues as pointed to the probability that a child had received an overdose of digoxin, but you couldn't, you said, arrive at that conclusion with any absolute certainty?

A. Correct.

Q. Have I reasonably summarized what you recall your evidence to have been? "

And here, sir, is the most important part:

"Are you still of those same views with respect to the toxicological data in the case of Stephanie Lombardo?

A. Yes. I had some reservations about the source, the quality of the fluid.

Q. Yes.

A. And what it was, whether it was contaminated or not. I was concerned about our lack of experience with



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2 exhumed tissues, and the fact that
3 possibly dehydration or drying of the
4 tissues could have concentrated
5 digoxin and made it up here higher
6 than it actually was. However, it
7 would be very, very difficult to
8 explain, even if his levels were
9 within a therapeutic range, you know,
10 why would they be there and this
11 child was not prescribed digoxin.
12 Not only that, but if the child had
13 accidentally received one dose of
14 digoxin you would not expect to have
15 even therapeutic levels in the tissues,
16 and certainly not in the fluid if
17 it were blood, and of course, we don't
18 know exactly about that."

19 He said, again, in answer to Mr. Lamek:

20 "I think more than that, perhaps the
21 fact that these levels are really
22 quite high, you know.. I think all
23 levels are considerably above what
24 one would consider normal therapeutic
25 range in these tissues. Of course,
as I say, we don't have a lot of



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experience with exhumed bodies and it
is difficult to interpret these
values."

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It continues to a question that

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Mr. Lamek puts to him:

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"Is there any question in your mind,
however, Dr. Hastreiter, but that
this child received one or more
prescribed doses of digoxin?

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A. No question at all."

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Says Dr. Hastreiter. And he said:

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"And you have to to some extent on
the basis of the levels recorded here,
I suggest you have expressed a very
qualified opinion on the quantitative
significance of those findings, have
you not?

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A. Yes. "

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He said:

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"Not within any range of precision
but you have said they are very high.
They are higher than you would expect
to find in the case of one mistaken
dose having been delivered to the
child?

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A. Definitely"

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Says Dr. Hastreiter.

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"Q. And I take it that they give you
cause for concern as to the liklihood
of digoxin having been involved in
this child's death?

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A. Yes."

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He said.

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Now, finally, sir, in a few lines
later, he makes the comments after commenting on
various techniques, and what have you, he said:

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"I know that the magnitude is so much
that I have little doubt about the
fact that this was not a maintenance
dose."

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Mr. Lamek put to him -- and this is
the final bit, sir, that I am reading to you. Sir,
Mr. Lamek put to him:

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"Q. Doctor, could we come at it perhaps
another way. If these levels had
been recorded in fresh tissue would
they have been consistent with the
concentrations that you would expect
to see in a child who had been receiving
digoxin on a regular ongoing way as



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part of a regime therapeutic
administration?"

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"no" he says, "they are much higher."

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"Q. They would have been higher
even in that?"

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A. These levels are much higher
than they would have been in fresh
tissue in a child who had been receiving
a therapeutic regime of the drug,
yes."

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Now, sir, I ask you to bear in mind here that I would
suggest to you lends to slightly great confidence
in the readings of Lombardo, not only the certainty
of the methodology and the mass spectrometry, but as
well as that, sir, with respect to Stephanie Lombardo,
she was never top seed, for better or worse, sir.
Although, it may never give us the answer with
respect to the glutted shunt.

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I suggest to you, that her body, in
terms of desiccation and dehydration, that that is
a fact that you can consider. As well as the fact,
sir, that she was never embalmed - whatever that might
do in fixing tissues or causing degradation or
causing whatever problems on the reading.

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Stephanie Lombardo was, well, sir,



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and was not embalmed. For, sir, some of those red herrings that may as well cloud the toxicology and exhumed tissue are not present in Stephanie Lombardo.

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You have there before you, sir, the highest order of testing here, and agreed upon certainty that there is pure digoxin in her system. You have not prescribed digoxin. You have her accutely sensitive to digoxin, sir. You have Dr. Hastreiter's saying not only has she got it, not only is she susceptible to it, she has, sir, more than one maintainence or therapeutic dose, sir.

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The conclusions, then, sir, that I lead to that - I would ask you to draw with respect to Stephanie Lombardo was that the tests established that digoxin qualitatively in a child for whom that it was not prescribed. But the magnitude of those numbers, sir, they are the highest that were ever seen in this time period with respect to exhumed tissue, and the pervasiveness of the digoxin, sir, in all the fluid and all the tissue digoxin was found in quantitatively, sir, high numbers and that it indicates, sir, that in fact, as Dr. Hastreiter has said that far be it that she got one dose, she got even more than a therapeutic dose. So, with that,



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sir, I would ask you to bear in mind the methodology is absolutely beyond question.

I ask you to bear in mind the tissues were not preserved, embalmed or autopsied.

That leads us to, sir, with respect to Lombardo the irreversible conclusion, sir, that Stephanie Lombardo was in fact given a deliberate overdose of digoxin and that it caused her death .

I suggest to you, sir, that really for lack of a better word here that in fact Stephanie Lombardo was marked for death when she arrived on that ward, and, in fact, sir, she was subsequently murdered.

I might say, too, sir, in terms of the pattern here, if you needed another matter, she has clinically got the symptoms, toxicology-wise she has got the reading that I have gone through with you. In terms of the pattern, sir, she is four square within that pattern. She dies during the course of the night. She dies in the course of the night she dies in the ward on 4B. And to that, sir, I want to allude to the fact that an individual that was associated to all 29 of the suspicious deaths that we have seen and that, again, that individual in a much quieter scene, a much more



CC-14

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2 isolated fashion, that individual, for whatever
3 inference you wish to draw, again, was present there
4 when Stephanie Lombardo was being treated. If you
5 like, then, by part - a distinct part of the 4A team.

6 I suggest to you, sir, that in
7 terms of the pattern - I don't think, with respect,
8 that she needs the assistance that the Cook death
9 and those pattern features give it. I think the
10 toxicology and the clinical symptoms are such that
11 there is no room for lack of certainty but if she
12 needed it, sir, she is four square with that pattern
13 and in the course features of that pattern.

14 I am not going to dwell, sir, on
15 the error theory here. In the broad scheme of things
16 Mr. Lamek, and Miss Cronk, have dealt with it. The
17 Atlanta Report has dealt with the unliklihood of
18 error and why many of these deaths do not show it.

19 I think it is clear, sir, that from
20 Dr. Hastreiter that the magnitude of the theory,
21 weigh more than the therapeutic dose indicates that
22 she was not even receiving another child's dose.
23 That dose she got was not meant for anybody in a
24 therapeutic sense on that ward. Just to be specific
25 Nurse Bucci's evidence at Volume 140, went through
that as far as she was concerned she certainly wasn't



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in her mind - I think Miss Cronk took us through the series of errors - the sequence of errors - and, really, sir, she couldn't entertain any reasonable possibility of having done that.

In terms of the nursing expert, Dr. McGee, the suggestion was, I think, the busyness of the day time shifts, the hectic pace there, may well be lead to or induce an error. Not so, again. Given the circumstances at night time and Christmas and the reduced ward population and, finally, sir, her situation was uncomplicated, sir, so far as she was on heparin, and I don't think, sir, that there is a real confusion with trained people between the heparin and the digoxin. Sir, they are labelled and are different, in place in that closet and in that cupboard.

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EMT/hr

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No nurses that we dealt with here, sir, as I saw presented as being rookies. It struck me, sir, that all were on that ward because they were experienced. Because, sir, they had shown coolness under fire. Because, sir, they had brought with them the ability, emotional and whatever, to deal with the particular situations that they would have.

I suggest to you, sir, members of the 4A team and 4B team for that matter were not the type of individuals who would be woolly-headed enough, sir, to be making any number of errors which would explain these deaths, or, sir, would explain the number of errors that would need to be made for Stephanie Lombardo to have been given digoxin instead of heparin.

One feature, though, with respect to heparin, set her up for perhaps an I.V. administration of digoxin because as indicated by Nurse Bucci that line was there, below the sage pump, the sage pump controlling the heparin in a very fine degree, but in fact, Nurse Bucci indicated that if one wished to give a direct dose of it into the I.V. line it could be done below the sage pump mechanism.

They differ, sir, on the time of



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2 administration. They differ, sir, with respect to
3 route. I am not going to go into it, sir. I don't
4 think you really have to make any finding. I think
5 once it is found in such large amounts, whether
6 Stephanie Lombardo got it in that last fed that she
7 took eagerly, as Dr. Hastreiter said she probably had
8 done or whether in fact she got it in an I.V. bolus as
9 Dr. Kauffman said and got it 30 to 60 minutes before,
10 I think it is clear from Nurse Bucci's evidence, the
11 night was so quiet, the child was so stable in fact
12 she was well able to go and sit at the nursing station
13 with a friend and the child was left unattended and
14 there was ample opportunity to have access to that
15 child and choose whatever route you wished.

16 With respect to the child Dawson, sir,
17 again just briefly on some of the features of that
18 child why, sir, I wish you to draw the conclusion
19 I am leading you to.

20 An 11 month old child died on July
21 28th. Again, sir, died at 2:40 in the morning.
22 She died in room 418 and she died, sir, when the
23 Trayner team was on duty.

24 She was in sir, as is peppered
25 through her charts, she was in for failure to thrive.
No particular surgery was planned, sir. She had



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2 prior surgery at the Hospital and surgery had been
3 successful. She had survived that surgery and had
4 gone to I.C.U., through the ward, being released
5 home.

6 Her mother, sir, had looked after
7 her. She was on digoxin, sir. Her mother had
8 administered that digoxin to her at home.

9 She dies, sir, suddenly, unexpectedly.
10 Her death, sir, is a cause for concern to all
11 involved. Her death, sir, and the cause for concern
12 here, it may well be that people could say that
13 Heather Dawson's evidence and it goes back to this,
14 could be self-serving. We could all say that, but
15 the surprise and the consternation at Amber Dawson's
16 death, sir, is noted independent record can be checked,
17 records that were there at the time. In the ward comm-
18 unication book it indicated that, sir, there was surprise.

19 If that wasn't enough, sir, as well,
20 Phyllis Trayner came here and said that such was
21 her concern that in fact she wished to intercept
22 Mrs. Dawson; she having left the child so stable
23 the night before and to see her arrive the following
24 day unaware that the child had died in the night
25 was something that Phyllis Trayner wished to protect
her from.



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2 Phyllis Trayner said that all the
3 nurses were surprised. So great was the concern,
4 sir, that the doctors themselves, Dr. Contreras
5 and Dr. Rowe, looked into the matter. As well as
6 that, sir, so great was the concern on Mrs. Dawson's
7 part, the surprise, that Mrs. Dawson brought in
8 the coroner.

9 Many said, sir, it is a speculative
10 question here; it is not something that really bears
11 objective marking, but some agree back in that
12 time period from a clinical point of view, clearly
13 looking at the child's symptoms and her condition
14 and what she was there for and what was scheduled
15 or not scheduled and looking back at the suddenness
16 of that child's decline, in fact, it was one of the
17 most surprising children, most unexpected deaths
18 until we hit March. And that, sir, was documented
19 in ward meeting books, and the nurses spoke of it, sir,
20 and the mother herself spoke of it.

21 If that wasn't enough you have the
22 activities of the mother herself. Her own innate
23 suspicion, her own common sense. Her own index of
24 suspicion caused her, sir, first of all to request
25 the coroner to be brought in. So great was her
concern about (a) medication and (b) the objectivity



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2 of the Hospital itself, sir, that she apparently
3 did firmly insist that the coroner be brought in
4 as she proceeded to get an outside pathologist.

5 I am sure as a credit to the
6 Hospital the coroner thought there was no lack of
7 objectivity if in fact it was referred back to
8 Dr. Cutz. And they did that.

9 Dr. Cutz did it, sir, bearing in mind
10 and mindful of the fact that the coroner was involved.
11 It was not a routine autopsy where there was no
12 concern or particular concern as to the cause of
13 death. It was clearly the coroner's case in which,
14 and you had this issue out with Mr. Scott, he just
15 wasn't being scientific and abstract; he was looking
16 for a real answer here. He knew he was working at
17 the behest of the coroner, and not only was her
18 death sudden and unexpected there was no cause found;
19 there was no cause stated in the autopsy itself.

20 Her symptoms sir, at the end with
21 respect again, classic, textbook symptoms of digoxin
22 toxicity. The days, sir, repeated reference to
23 lethargy floppiness of her limbs, drowsiness, sir,
24 vomiting, and the notes in the chart on page 84,
25 sudden onset, dramatic changes, bradycardia and again,
sir, failure of resuscitation efforts.



DD-7

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3 With respect, sir, not only does she
4 have symptoms - Lombardo had symptoms, other had
5 symptoms, but those symptoms, and the sudden and
6 rapid decline, sir, caused consternation in all of
7 those objective individuals who were treating her
8 at the time, unaware of a pattern, unaware of any
9 sinister things likely to happen.

10 And I think, sir, with respect, that
11 that feature, their concern, their recording of that
12 concern, the coroner being involved, his ability
13 to give a cause of death, the mother's concern ,
14 with respect, sir, indicates a high level of suspicion,
15 an index of suspicion, if you like.

16 The toxicology, sir, is problematic.
17 There is a reading four days before her death of
18 4.9. The therapeutic range, sir, and there is no
19 surprise that she was on digoxin.

20 Sir, with respect, I think I can sum
21 it up to a large extent here when those methods in
22 which we place any reliability were used, HPLC and the
23 IRA they in fact reveal, sir, in the heart and lung
24 no true pure digoxin.

25 This, sir, though was in tissue which
was fixed for approximately 18 months. I think it has



1
2 been urged upon you by individuals that therefore
3 leads to the conclusion that there was not a toxic
4 overdose of digoxin.

5 Sir, with respect, that does not
6 follow. First of all, sir, you have Dr. Cimbura's
7 testimony which shows that fixed tissue over 6 months
8 degrades, digoxin degrades. It is soluble in fixative,
9 sir, and it degrades and in fact it leads to a
10 lower reading than would have been in fresh tissue.
11 That is clearly there and Dr. Cimbura's testimony.
12 It wasn't challenged.

13 There could be no other case clearly
14 more clearly supportive of Dr. Cimbura than that of
15 I believe it was Cook himself where you have, sir,
16 the fact that Cook has in fresh tissue enormous
17 reading and when that tissue was looked at again
18 after being fixed in solution for a long period
19 of time the reading was completely out of whack.
20 Again supportive of Dr. Cimbura's findings that
21 there was in fact tremendous degradation.

22 I would submit to you, sir, that the
23 toxicology then is neutral. In a certain sense,
24 sir, it is so clearly out of whack she being on digoxin
25 and properly prescribed digoxin in fairness if the
toxicology was to have any meaning there should be
some increases on HPLC and



1
2 RIA. There should be some digoxin. There was none.
3 I suggest to you, sir, it is clear if there was any
4 digoxin clearly after 18 months of fixed tissue it
5 has in fact all degraded.

6 What do you have then left with the
7 child Dawson, sir? You have, sir, the symptoms
8 that I have given you; the sudden decline, all the
9 symptoms of digoxin toxicity that she exhibited in
10 the last few hours and days of her life.

11 You have secondarily, sir, the record
12 of concern of those people there who were shocked
13 and surprised at her death.

14 You have, sir, that she is four-
15 square in the pattern that Justin Cook as I say has
16 given new meaning to. Dies on the ward, died in
17 the presence of the team and all the other features -
18 I don't need to repeat.

19 And you do then finally, sir, have
20 another piece of evidence and that, sir, is the
21 role the mother has played here. The mother is
22 uniquely qualified, sir, having cared for her, having
23 had the experience and there was a marginal overdose
24 of digoxin on Christmas day - if there was ever any-
25 thing that could indicate to her the low margin of
error that is required in digoxin that was impressed upon



1
2 her and she took the child to the Hospital so she
3 was uniquely not only in the position as the mother.
4 but uniquely qualified because of the fact she had
5 been giving this child digoxin therapy, she was qualified
6 to register surprise.

7 She did that, sir, and she acted
8 upon that, sir. She didn't come to you and just
9 state to you idly about what her concerns were, that
10 she might have kept in her heart of hearts.

11 She indicated who she spoke to, Dr.
12 Olley. She indicated what she told Dr. Bunt, and
13 she indicated how she reacted to Amber's death. And
14 that much later she thought there was an explanation
15 and how she returned to the Hospital in case there
16 were any ruffled feathers there that she hadn't
17 gone over their heads.

18 I suggest to you, sir, that those
19 activities on behalf of the mother back there in
20 March with respect to that child show to you, sir,
21 a level of suspicion but also a piece of circumstantial
22 evidence to use as supportive or corroborative of
23 the cause of Amber Dawson's death.

24 Those, sir, are all my submissions
25 with respect to the children that I act for, sir.

Again, I thank you for your patience
here and your co-operation in that regard.



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THE COMMISSIONER: Thank you, Mr.
Shanahan.

Mr. Olah, do you want to proceed now?
We will be taking a break in the ordinary course at
about 3:30.

MR. OLAH: I would suggest, sir, that
we have a break now and proceed right on through,
if I may.

THE COMMISSIONER: Yes. All right.
20 minutes.
--- Short recess.

(*note page 1942 follows)

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/RD/ko

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THE COMMISSIONER: Yes, Mr. Olah.

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ARGUMENT BY MR. OLAH:

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Mr. Commissioner, at the outset of my submissions to you I, like other Counsel before me, would like to thank you, sir, for the considerate, the consideration we have had in our submissions and throughout the some 155 days we spent before you. This has been very difficult, both in legal and in factual areas of the Commission and it is one that has been highly visible in the media.

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I submit to you, sir, that because this Commission has received so much publicity, because it has come into the homes of the citizens of this community, they have seen that this Commission, like so often the judicial process, is painstakingly fair, always fair in the close scrutiny to which facts have undergone and that every conceivable piece has been unearthed and examined very closely. For that reason I submit to you, sir, that this has been, other than all of the other factors that have been involved, namely the report eventually, has been a very salutary matter.

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I would also like to thank both Counsel who have been here, and particular Commission Counsel, Mr. Lamek and Miss Cronk, who have been very fair,



eminently fair to all of us and have put in many hours of work that may not be reflected to the public, but co-counsel note the kind of work that has gone into preparing this submission.

I would like to also thank my co-counsel, and in fact some of the ones who have not received the visibility that maybe they deserved, such as Miss Fineberg, Miss Thomson, Mr. Batty and Mr. Young.

Turning to my submissions, whether you accept Mr. Scott's, what I have called scientific uncertainty tests, or whether you accept Mr. Hunt's presumptive approach or Mr. Lamek's probability test, I suggest to you that the evidence clearly leads you, must lead you, sir, to a conclusion that unfortunately there was someone who harmed children in this great hospital.

I suggest to you that unfortunately Mr. Strathy's accident theory just cannot be sustained in the face of direct evidence you have had about no digoxin being on the crash carts and particularly you will recall the evidence of my client in that regard that she never saw digoxin on the crash carts in Wards 4A and 4B throughout the period of time she worked on the that ward and she was responsible very often



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2 at nights for checking the crash carts and ensuring
3 that it was re-stocked.

4 So that in my respectful submission,
5 and of course this evidence is reflected and concurred
6 in by other people, such as Mrs. Scott. So we are
7 left, in my respectful submission, with a very
8 unfortunate but inescapable conclusion and that is
9 that some of the 36 children that you must look at, whose
10 deaths you must look at, died of deliberate admini-
11 stration of digoxin in toxic doses.

12 Now, the problem that I have, and what
13 I am going to direct my submissions to, is that it has
14 been suggested by Mr. Lamek and a number of other
15 Counsel that there is a common thread running through-
16 out the evidence and one of the main common threads
17 that has been pointed at is that the members of the
18 Trayner team were present at many, if not all of the
19 deaths. It is towards that common thread that I will
20 be submitting or making my submissions to you, and
21 basically they will break down to three areas: number
22 one, that Janet Brownless was not a member of the
23 Trayner team; number two, that she was not there for
24 a large number of the suspicious deaths, as categorized
25 by Mr. Lamek, that in fact of the three suspicious
deaths, at which she was present, that she had no



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access or contact with the children in two cases and, thirdly, that the pattern of suspicious deaths was well established long before my client commenced her employment at the Hospital for Sick Children.

I would like to then turn to the first submission and that is my submission that is clear on the evidence that Janet Brownless was not a member of what has become called the Trayner team.

You will recall, sir, the evidence of Mrs. Radojewski who told you how teams were structured, that generally there was one team leader, two registered nurses and one registered nursing assistant. In other words, there were four members to every team and that the Trayner team was composed of four members: Mrs. Trayner, team leader; two registered nurses, Miss Nelles and Miss Scott, and one registered nursing assistant, Mrs. Christie.

She also told you, sir, at Volume 115, page 5816, that Janet Brownless was not assigned to a team, that she floated among four different teams, in fact.

You will recall Exhibit 375, which was an analysis or a table outlining as to when Miss Brownless worked with the Trayner team and when she worked with other teams.



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THE COMMISSIONER: This is exhibit?

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MR. OLAH: 375. I can summarize it
for you if I may.

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THE COMMISSIONER: Yes.

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MR. OLAH: This was the evidence of
Mrs. Radojewski at page 5997 to 8 of Volume 115. That
approximately 55 times of a total number of times
during the epidemic period that Miss Brownless was on
duty she worked with teams other than the Trayner
team and 28 times with the Trayner team, so there was
a ratio of approximately 2 to 1 whereby Miss Brownless
worked with teams other than the Trayner team and a
breakdown in terms of long nights was 23 long nights
with teams other than the Trayner team; 16 long nights
with the Trayner team; 32 long days with other
teams and 12 long days with the Trayner team.

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In her evidence Miss Brownless confirmed
Mrs. Radojewski's evidence and also the exhibit and she
told you, sir, that during the nine months, the
epidemic period that you are considering, at no time
was she told that she would work with a particular team
and that, in fact, she was considered a floating staff
member, who could and, in fact, was assigned to any of
the four teams.

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So then, in my respectful submission,



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2 it should be clear in your report that when there is
3 a reference to the so-called Trayner team that that
4 reference involves only the four members of the team
5 that I have alluded to, namely the team leader, the
6 two registered nurses and the one registered nursing
7 assistant, being Mrs. Christie.

8 I would respectfully draw to your
9 attention a pattern that emerges in an analysis of my
10 client's shifts, in that she worked 55 shifts during
11 the epidemic period with teams other than the Trayner
12 team and at no time, as I recall, was there a suspicious
13 death that occurred on those shifts, including 25 long
14 night shifts and nothing suspicious occurs.

15 That probably explains why in the
16 Atlanta Report, Exhibit 324, Table 9, you will recall,
17 Mr. Commissioner, that Table 9 was the frequency of
18 nurses on duty at time of onset of terminal events,
19 ward associated deaths during the epidemic period,
20 and that my client, Miss Brownless, is 13th in terms
21 of frequency behind a number of other people, such as
22 Nurse Lyons, Halpenny, Reaper, Bracewell, Bell,
23 Harwood-Jones, Frise and one other. Parcels was the
24 last one.

25 On Table 11, which you will recall at
page 44, was a table that brought together a relative



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EE 7 risk of death analysis. There are only 12 nurses listed on that and nursing assistants listed on that table and my client is not on that table at all.

I suggest to you, sir, that a very clear pattern emerges in this case and that is that Janet Brownless is not part of the pattern that we have alluded to so often here and I respectfully urge that when you report on this matter that that be made abundantly clear.

Now, I would like --

THE COMMISSIONER: Perhaps something obscure might be done, but certainly it can't be made abundantly clear with the Court of Appeal Ruling.

MR. OLAH: I will get to that in my submissions, because in my respectful submission there is a distinction to be drawn in the Court of Appeal Ruling; one is that you cannot name names, which is really a catchall for a statement by the Court of Appeal, that you cannot make legal findings of responsibility. You cannot name and hold someone criminally or civilly responsible, nor can you come --

THE COMMISSIONER: It is more than that, because I couldn't do that anyway. I couldn't name the names, because that in effect --

MR. OLAH: I am saying there is an



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additional component and I will come to that in due course if I may and that is not only can you not make legal findings, but you cannot make factual findings according to the Court of Appeal that tantamount to a legal finding.

THE COMMISSIONER: That's right.

MR. OLAH: But that does not, in my respectful submission, and I will deal with it in due course, prevent you from making subsidiary findings of fact which are part and parcel of your reporting duties as outlined by the Court of Appeal.

In my respectful submission, while you cannot say on the facts, as much as I would like this, Janet Brownless had no involvement or no legal involvement, it does not bar you from saying, making findings of subsidiary fact which are, such as Janet Brownless was not a member of the Trayner team and that she was not a part of the pattern that links these babies and their causes of death.

That, in effect, was what Mr. Sopinka was telling you the other day also, as I understood him.

Now, I would like to turn --

THE COMMISSIONER: I am sorry, what was he telling me?



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MR. OLAH: I believe he was making a similar submission to you that you could not find his client a part of --

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THE COMMISSIONER: He never suggested his client wasn't a part of the team. What he did suggest was his client had not participated in the deaths; that is all.

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MR. OLAH: Part of the pattern. I am saying not only is my client not a part of the team --

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THE COMMISSIONER: How could I possibly say that his client and your client were not part of the pattern and not say that everybody else who was not there all the time was not part of the pattern? Where would that leave me? I just can't do it.

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MR. OLAH: In my respectful submission, at the very least, you can say that my client was not part of the team.

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THE COMMISSIONER: That is possible.

Your client certainly was a part of the team for some purposes. Your client was one of the persons who was relieved of duties on the 22nd of March.

MR. OLAH: But your Lordship will recall that she is also the - she and Mrs. Christie - are the only ones that are presently on Ward 4A/4B.

THE COMMISSIONER: Yes. Yes.

MR. OLAH: And that while she was relieved of duty for several days that doesn't deny, or negate, the factaul finding that I am asking you to make. And that is that she was not a part of the Trayner team.

THE COMMISSIONER: Yes. All right.

MR. OLAH: Now, there were - as I understood Mr. Lamek in his submissions - there were eight cases of deliberate administration of toxic doses of digoxin. I won't run through them because the seven are obvious. Kristin Inwood was the eighth in that category. They ranged from Cook to Inwood.

He submitted to you, sir, that there were four highly suspicious deaths. Laura Woodcock he termed as "grave suspicion", John Onofre "highly suspicious", D'Arcy MacDonald "quite high level of suspicion", and Real Gosselin "relatively high level of suspicion".



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And then there were four that were at sort of a medium level of suspicion, and they were Amber Dawson, who he termed "a nagging question",-- he termed it "a nagging question", Brian Gage "suspicious", David Taylor's death, in his submission, "involved a measure of suspicion", and Antonio Velasquez' death was also, in his submission, "raised a measure of suspicion". It will be my ultimate submissions, as I indicated to you at the outset, that of these 16 children, my client was not present on 13 occasions. She was not present, not only at that time that death occurred or the time the arrest occurred, but not even when, according to the pharmacological evidence, the very earliest possible dose of digoxin could have been given.

And the first child that I would like to deal with is the case of Kristin Inwood. You will recall, sir, that Kristin Inwood died on March the 13th, 1981 at 3 a.m. and she arrested at 2:30 o'clock in the morning. Miss Brownless worked a long day shift on March the 12th.

THE COMMISSIONER: Just hang on a second. Have we got all of that information? We have all of that information, do we not?

MR. OLAH: If you look at Exhibit 376,



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which is the chart that I prepared ...

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THE COMMISSIONER: Yes?

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MR. OLAH: ... or Exhibit 385 --

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THE COMMISSIONER: 383, is it not?

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MR. OLAH: I am sorry, sir.

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THE COMMISSIONER: 383.

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MR. OLAH: 3 - let me just - 383, yes.

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MR. OLAH: 376 will show you when

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Miss Brownless worked and what precise shift she

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worked. And 383 summarizes who was on and who was

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off.

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Now, it was Dr. Kauffman's evidence --

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THE COMMISSIONER: No - 376 or - I

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will keep that. Yes. Thank you. Yes?

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MR. OLAH: It was Dr. Kauffman's

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evidence with respect to Kristin Inwood that an IV

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dose was somewhat more likely than an oral dose. And

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all of this is, of course, to be found in the summary

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that has been prepared by Commission counsel on digoxin,

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but assuming that a single IV dose was administered

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in a toxic level, Dr. Kauffman felt that it was

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unlikely that it was given earlier than three or four

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hours prior to the arrest and a multiple vial scenario

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would merely hasten the onset of symptoms. So, that



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in his view the earliest time at which the toxic dose causing death could have been given was three to four hours prior to arrest. And his evidence with respect to my client is to be found at Volume 83, at page 8021, and at page 8021 this is what Dr. Kauffman had to say in relation to this child's death. Commencing at line 13:

"So, that if my client were off the evening previously, at 7:30 in the evening, I take it, Doctor, that she could have had no direct involvement with respect to the death of this child?

"A. Well, I suppose I could answer that to the extent that I think it is somewhat unlikely.

"Q. Highly unlikely, Doctor?

"A. I will agree with you."

Similarly, Dr. Hastreiter felt that a change in condition of the child occurred at 2 o'clock in the morning and that the very earliest administration would have occurred at around midnight.

Dr. Mirkin was also of the same view. Both Dr. Hastreiter and Dr. Mirkin gave similar evidence as to Dr. Kauffman. Dr. Hastreiter, at



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Volume 80, page 7472 --

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THE COMMISSIONER: To save you time,
Mr. Olah, if you look at Exhibit 383 - I don't think
it has been questioned that your client was not on
duty except in the cases of McKeil, Estrella, Gardner,
Miller and Cook, but even if I accept all of your
submissions, and I go through all of the evidence,
where does it lead me? What can I do with it?

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MR. OLAH: Well, in my respectful
submission, you can make a subsidiary finding of fact
that my client wasn't on on the night of these
children's deaths.

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THE COMMISSIONER: Well, that is a
difficult finding to make without incriminating
someone else.

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MR. OLAH: With respect - with the
greatest of respect, my respectful submission to you,
sir, is that what the Court of Appeal has said to
you - and maybe I should deal with that issue at
this time - is one that you cannot make the overall
findings either in fact or law but it does not bar
you from making what I say are subsidiary findings
of fact that deal with the very real reporting
function as to who was there and who wasn't there.
Now, that was No. 1 submission.



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No. 2 submission. As Mr. Sopinka pointed out to you, if there is a common thread being drawn - that is, some sort of pattern being led - to lead you to the conclusion that death occurred as a result of a deliberate overdose of digoxin being given to a child, and a certain pattern - namely the presence of the Trayner team is alleged at all times - then I can demonstrate to you and you can make findings of fact that will indicate that my client is not part of the pattern.

So, I submit to you that on two bases that you can make those findings of fact. Perhaps, I should deal with the Court of Appeal Judgment because obviously it is posing you concern.

THE COMMISSIONER: All right. I will have to borrow it. We will have to get Miss Cecchetto a copy.

MR. OLAH: The Court of Appeal laid down four major propositions and those propositions, as I see them, are as follows. If you, sir, make a finding of non-accidental administration of a lethal dose of digoxin leading to death, you cannot name the person who gave it. (2) You have a duty to determine the cause of death. (3) That a finding of fact -- this is to be found at page 15 -- amounting



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to criminal or civil liability constitutes a finding of law as to criminal or civil liability. In other words -- and maybe we should look at this - at page 15, at the third line down, on the top of the page:

"In our opinion such a conclusion ... " That is civil or criminal responsibility:

" ... may be expressed by findings of fact which without more, when found against an unnamed person, constitutes a position of criminal or civil responsibility."

In other words, if you were to make a finding of fact that all of the elements in fact are there, without making a finding in law, according to the Court of Appeal, that tantamounts to a finding in law. So, what they have told you that you can do, sir, in my respectful submission, is simply to make all of the findings of fact and then leave the conclusions of law aside. They say that those are identical findings and you simply cannot do that.

They told you at page 18 that - about eight lines from the bottom, sir:

"That the Commissioner is obliged to hear all of the evidence relating to



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"the cause of death of the children and this would include evidence that tended to show that one or more of them died as a result of unlawful or negligent acts.

"While the Commissioner must not identify an individual as being legally responsible for death, he should analyze and report upon all of the evidence with respect to the circumstances of each death and, if he can, make recommendations."

So, that what you have got in my respectful submission is a general prohibition that you cannot make conclusions which are tantamount to findings of liability, either criminal or civil. But underneath them, per contra distinction, is that you are obliged to analyze and report upon all of the evidence. All I am saying to you is that you can make in your reporting function subsidiary findings of fact which don't amount to the kind of findings of fact that you are barred from making, and one of them is who was present and who was not present at certain deaths.

THE COMMISSIONER: You mean that I can or can't?



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MR. OLAH: That is what you can do. But you will have to analyze, in my respectful submission, each death and report upon the circumstances of each death, and in doing so, you will have to analyse the surrounding circumstances. Very obviously. You will have to report who was present and who was not present.

THE COMMISSIONER: I don't see how I have to report who was present and who was not present, because the minute I start doing that, who was present and who was not present, I may be naming names and I am naming names by accepting that.

MR. OLAH: Well, with the greatest of respect, the problem with this catch-all phrase that Mr. Scott has termed "naming names" is a misnomer because what you have got is a Court of Appeal saying that not that you can't name names, you can't make findings of fact or findings in law of criminal or civil liability. That is quite different than naming names. They are saying that you cannot make --

THE COMMISSIONER: Well, all right.

MR. OLAH: That is my submission.

THE COMMISSIONER: Yes. I understand. I understand what you are saying. You are saying that I can, as long as I do not in the final analysis,



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after examining all of these facts, simply say at the end that, therefore, that proves that so and so was responsible and so and so were responsible. As long as I don't do that I can do everything up to that point?

MR. OLAH: No. I don't say that. I say that, and I say in addition, that you cannot make findings of fact. Say (a), I find (b), (c), and (d) which would be tantamount to making the ultimate finding in law. But what you can make --

THE COMMISSIONER: You are expressing these things. I have read this thing until I am blue in the face. I know that is what it says, I just don't understand how to put it in -- how to apply it.

MR. OLAH: How do you apply it?

THE COMMISSIONER: Apply it.

MR. OLAH: In my respectful submission, what you do is analyse all the circumstances surrounding each death and then you --

THE COMMISSIONER: And then I say who was present on the scene at the critical time, is that right?

MR. OLAH: Yes. That is one of the facts, in my respectful submission.



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THE COMMISSIONER: Yes.

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MR. OLAH: That you can and should do.

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And leave it at that.

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That is what I say, the Court of Appeal says to you and they said to you the task is virtually impossible but you will have to try to balance your two functions. Namely, a reporting function so the community at large knows what transpired surrounding each death and the overall prohibition which says "beyond this line, you cannot go" and you will have to draw that line. And I suggest to you that in one of the places that you draw the line is that you can - on this side - on the reporting side of the line you can say who was present and who was not present.

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Certainly, I say to you with the greatest of respect, you can say that my client was not a member of the Trayner team. I mean, that is clear in the evidence. And in my respectful submission that is a finding of fact that you can and should make.

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THE COMMISSIONER: Yes?

MR. OLAH: ... in view of the direction that you have given me.

THE COMMISSIONER: I don't think you



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2 need to belabour it because certainly Exhibit 383 has
3 not been questioned.

4 MR. OLAH: All right.

5 So, the children that I say she wasn't
6 on for are as follows. We have talked about Inwood.
7 The next one is Kevin Pacsai, who we recall arrested
8 at 3:45 in the morning of March 12th, 1981.

9 My client had worked a long day previous.
10 She was off at 7:45 p.m.

11 Jordan Hines, who arrested at either
12 4:10 in the morning or 4:25 in the morning on March
13 8th, 1981. And you will recall that Miss Brownless
14 had worked the long day before and, in fact, she was
15 a friend of the Hines family. Mrs. Hines phoned her
16 at about 7 o'clock in the evening to see how the child
17 was doing before Miss Brownless left.

18 And all three cases Dr. Hastreiter and
19 Dr. Mirkin said to you, in cross-examination, that my
20 client could not have had any involvement, that she
21 wasn't present when the lethal dose was given - if a
22 lethal dose was given - and that was the view with
23 respect to Stephanie Lombardo because in relation to
24 Stephanie Lombardo, you will recall, sir, that she
25 died on December 23rd, 1980 at 4:20 in the morning.

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And Miss Brownless was absent from the Hospital between December 15 and December 24. In fact she was off - well, it is evident she was off all day the 22nd including the long night. She just physically was not present on the day that Stephanie Lombardo got into trouble and died.

Similarly with Jesse Belanger Miss Brownless was off between December 28th and January 4th inclusive.

By the way, for reference as you pointed out, Exhibit 383 is helpful. Exhibit 376, and also the WIN sheets, Exhibit 335 which confirmed that she was off in these cases. With respect to evidence you may wish to look at Miss Costello's evidence at Volume 97, page 1742.

John Onofre died on December 9th, 1980 at 4:10 in the morning; arrested at 3:29 in the morning, and again Miss Brownless worked the long day that day.

It is Dr. Hastreiter's view that the earliest possible time an elevated dose could have been administered was at 1:10 in the morning.

Laura Woodcock, one of the children Mr. Lamek viewed as nagging or nagging question, was well before my client commenced her employment in



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the Hospital for Sick Children on August 25th, 1980.
Laura Woodcock died on June 30th, 1980.

You will recall that Dr. Hastreiter
had a high index of suspicion with respect to this
death as did Dr. Mirkin who viewed his index of
suspicion as being 7 out of 10 in this case.

David Taylor was another child
whose death Mr. Lamek submitted merited some
suspicion, and again this unfortunate child died on
July 27th, 1980 well before Janet Brownless commenced
her employment with the Hospital.

You will recall Dr. Mirkin saying
that there was a very high likelihood of digitalis
intoxication in this case.

Amber Dawson died on July 28th, 1980;
again before my client commenced her employment at
the Hospital. So did Antonio Velasquez.

Brian Gage died on September 25th,
1980 at 3:20 in the morning. Miss Brownless worked
the long day previously.

Similarly with Real Gosselin who
died on December 18th at 3:17 in the morning. Miss
Brownless was scheduled to work the long day but was
ill and absent from the Hospital.

So that of the 16 deaths that Mr. Lamek



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submitted to you as being either deliberate
intoxication, highly suspicious or suspicious,
Janet Brownless was physically not present at the
Hospital on 13 occasions.

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THE COMMISSIONER: I thought Mr. Lamek
had it quite a bit above 16.

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MR. OLAH: Well, he had some that had
a low measure of suspicion, but I have taken only the
16 who had a measure of suspicion or high suspicion
or probable intoxication.

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If you review the 29 cases that are
listed on Exhibit 383, you will see that Miss
Brownless was on only six times.

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THE COMMISSIONER: Yes. And you say
that I can, can and should make comment on the
fact that she was not there and I assume it follows
that I should make the same comment about all the
other members of the team. You object to that term --

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MR. OLAH: Of course I object to that.

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THE COMMISSIONER: -- members of the
team. I should make the same comment for that?

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MR. OLAH: Well, sir, if their
solicitors of counsel wish that, then I am not here
to plead their case. I have no objection, but I say
that on the two grounds, namely what the Court of



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Appeal has mandated and also because of the pattern that has become one of the crucial factors in your consideration - it is submitted that it is a crucial factor - my client is simply not part of that pattern. She just isn't there.

Two other children I would like to deal with very quickly.

THE COMMISSIONER: Yes.

MR. OLAH: And that is Justin Cook. You will recall the evidence of both Miss Nelles, Mrs. Trayner, that Justin Cook was under constant nursing care on the morning of his death, and that either Miss Nelles or Mrs. Trayner was with that child at all times. And that the evidence in my respectful submission is clear that they were the only two nursing staff members who gave any kind of nursing care to Justin Cook.

In my respectful submission that warrants a finding of fact that Janet Brownless gave no nursing care of any kind to Justin Cook on that evening and morning.

In fact it was Mrs. Christie's evidence at Volume 122, page 7856, that Miss Brownless and Miss Nelles and Mrs. Christie had lunched together that night and that they returned



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to 418 at 3:40 in the morning and had been absent from 3 o'clock in the morning until 3:40 in the morning. And that essentially is going to be my submission as it relates to Janice Estrella.

You will recall that Janice Estrella was also on constant nursing care, sir, and that other than for a short period of time Mrs. Scott indicates Janice Estrella may have been left alone when Mrs. Trayner came to the nursing station; at all other times on the night, the long night of Janice Estrella's death this child was under constant nursing care.

It was Mrs. Christie's evidence that Janet Brownless was at the nursing station when Mrs. Scott came out on the first occasion on the Saturday night for her first coffee break, and there throughout the time that Mrs. Scott was.

Similarly that she had lunch with Janet Brownless later that morning and Brownless was with her for the entire 10 minutes that Mrs. Scott was at the nursing station on that second occasion.

It was Mrs. Scott's evidence that the only time that Miss Brownless was in the room, it wasn't clear whether it was Friday night or Saturday



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night, was that Mrs. Trayner was in the room in any event providing constant nursing care for Janice Estrella, and as a result in my respectful submission you should make the same finding of fact with respect to Janice Estrella as I asked you draw in the case of Justin Cook; namely Miss Brownless had no contact or gave no nursing care whatsoever of any kind to Janice Estrella on the morning or the evening prior to her death.

Now Charlon Gardner was another child for which Miss Brownless was on. You will recall that this child was on shared nursing care and Mrs. Scott was assigned to her and to a child by the name of Boissenault in 418.

It was Mrs. Scott's evidence that the two children were side by side. As a result she could keep an eye on both children and she was relieved for a brief period of time. It would appear to be that Mrs. Trayner relieved on that night also, and as a result, Mrs. Trayner's evidence and Mrs. Scott's evidence, no one else gave nursing care to Charlon Gardner and I ask you to make a similar finding of fact with regard to Miss Brownless that she had no contact with Charlon Gardner on the morning of her death.



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I would like to then turn to what has been called patterns and the stress level in that ward. You will recall the evidence of Miss Brownless, sir, that the first time she had patient assignment after her orientation had been completed was on September 8, 1980.

Now you will recall that she commenced her employment in the Hospital on August 25th and that she was on a period of orientation for two weeks. It was her evidence that during the first week she was on briefly after the Wednesday on the ward and mainly looking at lists of things that they had to get to know, such as where rooms were and where supplies were to be found.

On the following week she had no nursing assignment in the sense that there were no children assigned to her. So that the first time she assumed her role, the first time she had patients under her care was on September 8, 1980.

By this time I would respectfully point out to you that 12 children had died. A full one-third of the children whose deaths you are investigating, sir, had already occurred.

You will recall the evidence of Mrs. Coulson at Volume 108, pages 4478 to 79. By the



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last week in July she realized that there was a pattern emerging. Children were dying in the night, that the same team was on, and she reported this to her superiors and discussed it with Mrs. Johnstone. That discussion according to her with Mrs. Johnstone occurred probably on August 4th, 1980, and it was her evidence that this pattern was well established or entrenched by late August.

At page 4484 to 85 this is what she had to say in that regard:

"Q. I guess the point I am trying to make is simply this: that in late March when you first started suspecting that there was something possibly other than surgical deaths involved, it was pretty clear to you that that pattern that you observed in July was well entrenched and well established by late August?

"A. Yes.

"Q. And consequently Janet Brownless could not have had any involvement in that because, assuming that the evidence is correct, if she started on Wards 4A and 4B in late August or



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"early September, she could have
had no involvement whatsoever?

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"A. I agree with that."

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In my submission a pattern was
emerging clearly by late July and certainly was
well established by late August, the time that my
client came onto the ward to commence her employment.

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You will recall that was Mrs.

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Costello's evidence at Volume 97, pages 1729 to 30
that by September 2nd, 1980, she was aware of certain
factors; namely the marked elevation in the number
of children dying on the wards, that children were
dying in the early hours and a particular team was on.

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Susan Nelles testified that in retro-
spect she discerned - she now discerned that a pattern
emerged or was there in July or August of 1980. The
pattern was that deaths were occurring with the team
and they were occurring in the early hours.

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Coupled with that was the elevated
stress level that was occurring during the summer
months on the ward. You will recall that Carol Browne
testified at the end of July she was approached by
Nurses Trayner and Nelles about a death and whether
they had done everything humanly possible. And on
July 31st there was a ward meeting, and in mid August



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Dr. Freedom reviewed three children's deaths in an attempt to allay this concern.

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Then there was a meeting between Browne, Bell, Trayner and Nelles concerning further deaths in mid August, and about that time Miss Browne approached Dr. Rowe and eventually the mortality conferences of September 5th and September 26th were arranged.

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The stress level was so high during these two months in my respectful submission that they culminated in a request for psychiatric counselling for some of the nurses. You will recall when I asked Miss Browne whether this was unusual, at Volume 85, page 8618, she said that such a request in her experience was highly unusual.

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Susan Nelles' evidence that by the time she went on holidays on August 19th, 1980, the stress she felt was terrible due to the deaths of children who died on the ward during the summer months of July and August. So I submit to you that the pattern was well established by September 2nd, 1980, when my client was on the ward, and that if you find, sir, there was a perpetrator on the ward, that that perpetrator started striking as early as July and August of 1980.



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The other factor that I would like you to consider is the fact that Miss Brownless had no cardiology experience or knowledge when she arrived on the ward, consequently, could not be part of the pattern, because as the Atlanta Report points out, a perpetrator had to have intimate knowledge of physiology and cardiology.

You will recall Exhibit 374 which was the staff performance evaluation carried out by Mrs. Radojewski with respect to Miss Brownless on November 5, 1981. At Volume 115, page 5812, Mrs. Radojewski said that Miss Brownless was an excellent nurse, but that one of the areas where she needed improvement was in the knowledge of congenital heart defects.

So that after a year after her arrival on the ward it was her superior's perception or assessment that my client simply did not have sufficient knowledge of congenital heart defects of a calibre that she felt was required.

That is understandable, because my client was a registered nursing assistant and had never worked in cardiology before.

THE COMMISSIONER: Surely this has to do with identity, though, this argument, does it not?



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MR. OLAH: I say it goes to pattern.

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THE COMMISSIONER: It may go to pattern. I don't understand quite what you mean by that. It certainly also goes to identity, doesn't it?

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MR. OLAH: It may well be, but if you are going to deal with a common pattern that is going to lead you to tip the scale one way or the other, with respect to a certain death, you are going to have to assess who is part of the pattern.

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THE COMMISSIONER: I don't know why I have to assess who is part of the pattern at all. The pattern is the presence of the team. Does that mean that I have to identify who is part of that team and who the people are? Do I even have to mention their names at all?

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MR. OLAH: If you will say that my client wasn't a part of the team then I am satisfied with that.

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THE COMMISSIONER: Obviously your client was a member of the team from time to time and there is no question that she was. I don't know what you mean by a member of the team, because from time to time we would find one member of the team would be in some other team. We found that often. That applied to all of them, every member of the team.



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MR. OLAH: With respect, the evidence is simply that there was formally a team that came to be known as the Trayner team. There were four formal members.

THE COMMISSIONER: Yes, I know.

MR. OLAH: My client occasionally worked with them, more frequently worked with other teams.

THE COMMISSIONER: I understand that, Mr. Olah. The whole thing is unfortunate, but I am faced and we have been through it before --

MR. OLAH: Yes, we have, sir. I know the impossible burden that has been placed upon you, but in my respectful submission you can make some findings of fact that you are not barred from making and that for the sake of a woman, whose reputation has been affected by these proceedings, if you feel that you can properly make those findings of fact and, in my respectful submission you should. It is a very unfortunate, one of the tragedies of this proceeding and there are many, is that innocent bystanders, doctors, nurses, have had their reputations clouded and, in my respectful submission, there may be, and there are certain findings of fact that you can make that may, in the long run, resolve some of that cloud.



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Unfortunately, you can't do it altogether, but I say there are certain findings of fact that you can make and I am asking you to make them, sir.

THE COMMISSIONER: Yes, all right; thank you.

MR. OLAH: Now, I have dealt with the 16 children that Mr. Lamek alluded to. There are some children that my client was on for.

It may be argued that Laurette Heyworth was one of those children. She, of course, is not on Exhibit 383, because she is not a category A or B death. Mr. Lamek pointed out that this was a child with respect to whose death everyone agrees was a natural death.

Richard McKiel was one child, another child that she was on for. Richard McKiel died October 15, 1980. Mr. Lamek termed this death as a suspicion being aroused. I would point out to you, sir, that on the tour end reports, Exhibit 360, this child repeatedly occurred, his name occurs on the tour end report starting as early as September 28, 1980, noting that this child is in serious difficulty. On the 28th he is noted as the respiration is grunting, pale and vomiting. On the 11th of October there is a question about whether he is in failure. On the 12th



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H 5 2 it is noted that there is irregular apex, tachycardiac,
3 vomited once. On the 13th his concern about continuous
4 failure and then at 7 o'clock in the morning it is
5 noted that the child vomited his formula and that he
6 is in failure.

7 I submit to you that this was a
8 critically ill child and that this child's death should
9 be viewed in the natural death category.

10 THE COMMISSIONER: Just because the
11 child was critically ill, of course, does not mean
12 that the child was not poisoned by digoxin.

13 MR. OLAH: No. You are totally
14 correct, sir. It may be that that occurred, but I say
15 to you that the level of suspicion is so low that there
16 is no basis for saying that this was not a natural
17 death.

18 The only other two children that I have
19 not dealt with, for which Miss Brownless was on for,
20 were Antonio Adamo, whose death Mr. Lamek termed as a
21 natural death, and David Leith, whose death Mr. Lamek
22 placed in the same category as Heyworth, namely natural
23 death.

24 I have made submissions about Sharon
25 Gardner and the three final children: Estrella, Cook
and Miller. I haven't touched Miller; I don't believe



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I can assist you with respect to the Miller child.

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THE COMMISSIONER: As much as I admire him, I don't feel I am absolutely bound by what Mr. Lamek says. How did he rate in your scale, Mr. Hunt?

MR. HUNT: The babies?

THE COMMISSIONER: Adamo.

MR. HUNT: Adamo. Well, we moved him into the suspicious category.

THE COMMISSIONER: There you are. We don't just abandon that child because of your faith in Mr. Lamek.

MR. OLAH: I adopt the submissions of Mr. Lamek in that regard and I will leave it at that.

The other factor that you have been urged to consider is the events of August to October, 1980, so-called dirty tricks episodes and if you do consider that I would submit to you that you should have consideration to the following factors and that is that it was the evidence of Miss Brownless that after May or June of 1981, in a vast majority of cases she worked with teams other than the Trayner team and that during the period of August through to October, when a number of the incidents that you have heard of occurred, she simply wasn't present. I won't belabour them, but



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2 they are to be found at Volumes 116, page 6432 and
3 onward.

4 In particular, she was not there on
5 September 24th, the early hours of September 24th
6 when the famous soup and salad incident occurred at
7 1:50 in the morning. Miss Brownless had worked long
8 days the day before.

9 I have made submissions to you, sir,
10 about what I say your role is. I say that the Court
11 of Appeal has not barred you from making findings of
12 fact that deal with reporting on individual circum-
13 stances relating to the death of the children.

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I have also said that you should take into account the factors that I have enumerated, because you have been told that one of the threads tying this case together is a pattern and I say that Janet Brownless is not part of that pattern.

There were two matters that I wished to deal with briefly. Firstly, I feel obliged to respond to Mr. Percival's comment the other day about nurses working in conjunction, possibly. I have to respond to it, because I don't want anyone to suggest that it is accepted in these quarters.

The only piece of evidence that gave rise to any foundation whatsoever was a question that Mr. Percival put to Mrs. Radojewski at Volume 113, page 5655, which was this, commencing at line 18:

"Q. Well, when you talk about; when you say I suppose their chances would be very slim, would you agree with me that if there was more than one person that the chances of one acting as a perpetrator and one acting as a look-out, the chances of being detected are almost nil?

"A. Yes."

This was a hypothetical that he put.



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THE COMMISSIONER: I think there was also from Nurse Frise, was there not, on that subject, that she expressed the view to the police --

MR. OLAH: It may well be she considered it. In any event, I respectfully urge upon you that there is no evidence whatsoever to support that submission. In fact, in my respectful submission the evidence quite strongly points the other way and I point to the death of Stephanie Lombardo where three members of the team and my client were off.

MS. RAE: Mr. Commissioner, I suggest that this is really going to identity.

THE COMMISSIONER: You are going too far, Mr. Olah.

MR. OLAH: All right. The submission that I have is that there is no factual foundation for the allegation advanced by Mr. Percival and I leave it at that. In my respectful submission it should be rejected forcefully.

The only other matter that I wish to urge upon you, sir, is this: this has been a difficult process for everyone. There has been difficulty in a complex web of facts that has emerged and difficulty in interpreting the mandate that was



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imposed upon you. This was very much due, in my respectful submission, to the ambiguity of the counsel. This is borne out by the fact that a number of judges have given different interpretation to the Order in Council.

As a result of the interpretation, during the course of the Commission, the character and mandate of the Commission has changed and I am concerned very much about a remark that was made on October 18th, 1983, sir, when you suggested, 'you will recall, at Volume 51, as to why members of the Trayner team were here and I know now that that comment is not applicable.

THE COMMISSIONER: No longer valid.

MR. OLAH: No longer valid.

THE COMMISSIONER: Knowing the interpretation I doubt that --

MR. OLAH: I want that clearly on the record. I am much obliged for that assistance.

In conclusion, as I have said before, sir, this is a case that has been fraught with tragedies, tragedy of parents, who will never have the ability to raise and to have these children and tragedy of young babies, who will never be able to enjoy life and the marvels of life and tragedy to a



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world renowned hospital, but tragedy also of the innocent bystanders in this Hospital, doctors and nurses, in particular my client, whose reputation has been brought under a cloud simply because they were working in this great Hospital.

I know that you will do your best to resolve the many conflicting interests that are imposed upon you and I am very grateful again for the assistance and the patience you have had with me; thank you.

THE COMMISSIONER: Thank you, Mr. Olah. We will rise now until 10 o'clock on Monday. At that time we will strike back up the line and I suppose I should rightly assume that if no one is here on Monday that they have no reply to give. Isn't that a reasonable assumption?

MS. CRONK: I think there is a deeming provision that applies, but apart from that, can I ask you as well, it would be very helpful to us, if we could get time estimates from counsel who are present as to how long they will be in reply.

THE COMMISSIONER: There aren't that many. Perhaps we could have some indication?

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THE COMMISSIONER: I guess, Miss Thomson, have you decided how long Mr. Scott will be?

MS. THOMSON: I think we will probably be somewhere between an hour and a half, two hours.

THE COMMISSIONER: Yes. I should of recorded first because obviously we have taken you the group that is coming on -- Mr. Young would be coming on first. Have you any thoughts with that?

MR. YOUNG: We will be very brief, Mr. Commissioner, with our submissions, if we have any reply.

THE COMMISSIONER: An hour and a half, you think?

MS. THOMSON: I would think so but that is probably an outside estimate.

THE COMMISSIONER: We don't see any of the others here.

MS. CRONK: Mr. Commissioner, Mr. Strathy's associate is here, sir.

THE COMMISSIONER: Oh, yes, of course.

MS. RAE: I am not sure how long we will be here but I don't think it will be duly long.

MS. CRONK: I don't know what that means.

MR. BROWN: We might well be a half an



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hour, sir.

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THE COMMISSIONER: Well, I think you can tell the answer to Mr. Lamek that there is a good chance that he will be reached.

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MS. CRONK: He certainly knew that sir, but this will be helpful. Thank you.

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THE COMMISSIONER: By the end of Monday. At that may well be that we will wind things down some time on Tuesday, the end of Phase I.

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Have you any proposals to put to anybody?

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MR. HUNT: Well, yes I did.

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THE COMMISSIONER: As I happen to run into him on the street. That is the only reason.

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MR. HUNT: It is in connection with the scheduling in July. There is one last effort on the part of Ms. Cecchetto and myself to work out something acceptable to everybody that would also have the effect of freeing up July 16th because of my commitment.

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THE COMMISSIONER: Tell us about your commitment. You are too much away... are you lecturing every day?

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MR. HUNT: Yes.

THE COMMISSIONER: Every day?



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2 MR. HUNT: Well, there maybe one
3 that I am not.

4 THE COMMISSIONER: You are almost
5 as badly treated as a resident doctor. One day or
6 not, which day is that? That would turn out to be
7 a Friday or Monday, I guess?

8 MR. HUNT: I think it is Friday, the
9 20th.

10 THE COMMISSIONER: It would be. Yes?

11 MR. HUNT: Here is the proposal. In
12 order to not cut down on the number of sitting days
13 too drastically, the suggestion is that instead of
14 Tuesday, Wednesday and Thursday of the week before,
15 the 10th, 11th and 12th, we sit Monday to Friday
16 that week and that would then mean that there would
17 be five days there instead of three. So, that the
18 end result is we would only lose one sitting day
19 over the proposal that now stands. And the alternative
20 of that would be suggesting that we sit two days
21 on the week prior to that, on the 4th and 5th and
22 then the 10th, 11th and 12th -- I know that gets
23 back into problems of production of documents and
24 schedules and so forth.

25 THE COMMISSIONER: Well -

MS. CRONK: I have a counter proposal,



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sir. I am perfectly content if Mr. Hunt would like to be here during the working day - the week of the 16th. He could lecture to us here. I have no problem with that, sir.

THE COMMISSIONER: Well, what is the result going to be? Does this mean that the whole Crown Attorney business falls apart you are --

MR. HUNT: I don't know.

THE COMMISSIONER: Either you don't go or you do go, does the participation in Phase II fall apart?

MR. HUNT: Well, I think --

THE COMMISSIONER: Well, what I was hoping was somehow that one of your clients would not be in the - make any arrangement that you like for postponing cross-examination, and that sort of thing for you, if you wanted.

You see, the witnesses that we are going to have on Phase II are going to be available, generally speaking there all here and it wouldn't be too difficult to call them back if you wanted - if you wanted to forego as long as we don't have any -- I don't know, I am just assuming that we are going to work the five days and I am also assuming, Miss Cronk, that you are not going to be ready the week



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2 before?

3 MS. CRONK: The week before is just
4 not, practically speaking, possible, sir.

5 THE COMMISSIONER: Have you any
6 thoughts on that?

7 MR. YOUNG: Sir, Mr. Hunt's first
8 proposal would be agreeable to us. We would be happy
9 to --

10 THE COMMISSIONER: Work the five
11 days?

12 MR. YOUNG: Work those five days if
13 it goes five days and then return a week later.

14 THE COMMISSIONER: Well, we won't
15 return -- yes - we won't return then until August.

16 MR. YOUNG: That is even better.
17 No, that meets with our approval, sir.

18 THE COMMISSIONER: What do you say?

19 MR. BROWN: Well, in the spirit
20 of co-operation with the office of the Chief Officer
21 of the Crown, I don't have any objection to working
22 five days the week before.

23 THE COMMISSIONER: What do you say
24 about that, Miss Rae?

25 MS. RAE: I don't think we have any
objections.



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2 THE COMMISSIONER: All right.

3 MS. CRONK: Sir, can I just add one
4 thing to ...

5 THE COMMISSIONER: Yes?

6 MS. CRONK: Neither Mr. Lamek or
7 myself are unsympathetic to difficulties that I under-
8 stand both Miss Cecchetto and Mr. Hunt have. Miss
9 Cecchetto, as I understand, is scheduled to be at
that conference as well.

10 MS. CECCHETTO: As a student.

11 MS. CRONK: Well, whatever capacity,
12 I know there is a problem. But could I just in
13 your consideration add a further difficulty here.
14 You are quite right that those witnesses that we
15 anticipate would be called in Phase II are resident
16 in Toronto, so there is no difficulty in calling them
17 back, but we have been put on some considerable
18 notice from counsel, both for the police and the
19 ministry, that there are the natural scheduling
20 problems attendant with the summer and it is complicated
21 for a number of the police officers by the visit,
22 both as it is currently scheduled for the Pope and
23 the Queen. I don't wish to overstate it but there
24 is fear, although not unrealistic, that we may have
25 difficulties in August in scheduling some of these



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2 witnesses. And I am not being unsympathetic, and
3 we certainly have no objection to sitting that five
4 day week but, I do add as a caveat, that we may have
5 difficulties in August and we shouldn't likely plan
6 not to be sitting for three weeks in July. And,
7 regrettably that is a comment that I have to make.
8 That is a comment after discussing with Mr. Lamek.

9 THE COMMISSIONER: Well, let's just
10 leave it at that. We will try. I don't think we
11 should decide that right now. I think we will
12 see what we can do to accommodate you and, perhaps
13 we can make the decision - I mean, on Tuesday, or
14 whenever, the close of business is for Phase I
15 because we may know a bit more about how things are
16 going to be sorted out.

17 MS. CRONK: Yes.

18 THE COMMISSIONER: Then -- I don't
19 like the idea of being off for three weeks. The longer
20 we are off, the harder it is to get back on. And
21 the three days we can - well it seems to be casual -
22 at least we don't have time to forget what's gone on
23 before. If three weeks were wasted there to try and
24 get back to --

25 MR. HUNT: If it is of any assistance,
Mr. Commissioner, as far as I am concerned, my first



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2 comment is here and if it works out better, or it
3 is inconvenient or unacceptable to anyone --

4 THE COMMISSIONER: We will try to
5 sort it out that week end. And we can advise you
6 and we will settle that on Tuesday. And you can
7 think about it in the meantime.

8 All right. Well, then, we will go
9 back up the line starting at 10:00 Monday.

10 ---Whereupon the hearing was adjourned at 4:30 p.m.
11 until Monday, the 25th day of June, 1984 at
12 10:00 a.m.
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